Anthem

Anthem Blue Cross and Blue Shield

Dental Provider Reference Manual

(for CO, CT, GA, IN, KY, ME, MO, NH, NV, OH, VA, WI)

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General Information

Section 1:

About Anthem Blue Cross and Blue Shield

Anthem Blue Cross and Blue Shield (Anthem) and its affiliates offer a variety of dental plans for its members nationwide. These dental plans make available primary and specialty dental services. Our dental plans are created to provide you with choice regarding fees that are acceptable to you and create new opportunities to grow your dental practice.

Today's consumers of dental benefits desire more plan choices than at any time in the past. Having access to multiple dental PPO networks allows Anthem to market a greater variety of plans to our customers, increase choice for your patients and create opportunities for you.

What is a Dental Plan?

A dental plan is a product an employer group or an individual buys from a company who offers dental benefits, in order to offer their employees assistance or to have assistance with the payment of dental benefits.

Dental benefit plans are better characterized as financial assistance plans rather than as insurance. Unlike true insurance plans, which are designed to protect against major loss, dental benefit plans provide financial assistance to members and their families to encourage regular visits to the dentist, which are essential to maintaining oral health. Most dental plans are structured to provide coverage that meets the basic needs of the general population.

Dental services are less costly and more predictable than medical care. Dental plans typically feature a specific set of benefits and coverage parameters and are not always designed to address each individual's specific dental treatment needs.

Specific dental care needs vary for each individual and should be discussed with the patient. Depending on the member's oral health circumstances the dental plan may or may not cover all of their needs, and should not be the sole determinant of the dental treatment that they receive.

Anthem offers insured products where the insurance is underwritten by Anthem; administrative services to self-funded groups or unions who have an Anthem product; and services to provide Anthem products to health care exchanges.

How is the actual benefit plan determined?

The ***employer*** determines the combination and extent of dental benefits for an employee's program by purchasing the plan that fits their needs. If the dental benefits are purchased by an individual the person purchasing the plan makes the determination of which plan fits their needs. Anthem is responsible for administering the plan, making appropriate payments according to the plan benefits and maintaining the integrity of our dental networks.

How does a Dental Network differ from a Dental Plan?

A Dental Network is:

Comprised of dentists that have agreed to provide dental services to a dental plan's members at a specified reimbursement. Within a network there can be more than one plan for the employer group to select from.

A Dental Plan or Product is:

A dental plan is a product an employer group buys from a company who offers dental benefits, in order to offer their employees assistance with the payment of dental benefits.

Dental PPO (Preferred Provider Organization or Participating Provider Organization) plans are perhaps the most common type of dental insurance plans. Most dental PPO plans require the patient to pay Co-insurance and/or a deductible. Each one of those plans may have different amounts for the deductible, the yearly maximum, what procedures are covered and at what percentage.

See Section 2, Provider Networks and Plans, for the list of Anthem's state specific networks and plans those networks serve.

Responsibilities of the Dentist

As a participating dentist you agree to recommend and provide dental services in the best interest of each individual patient's oral health needs. You are also obligated and strongly encouraged to:

- Identify which plan patients are on and which network services that plan;
- Obtain a current copy of the patient's identification card at each dental visit;
- Submit claims for your Anthem patients timely and accurately;
- Accept the allowed amount for covered services and direct payment from Anthem, Affiliates, self-funded groups (may use Third Party Administrator), National GRID program as applicable to Participating Agreement;
- Provide to the member a written recommended treatment plan and cost associated with covered benefits and non-covered benefit options to ensure all parties are well informed of treatment plan and agree prior to services being rendered;
- Submit diagnostic aids (such as x-rays) as necessary;
- Update Anthem's dental Professional Services department with your most current dental practice information (i.e., adding new dentists to your practice, credentialing information, address changes, Tax Identification Number (TIN) changes, change in ownership, etc.) on a timely basis or as required by your Participating Agreement; and
- Provide quality dental services to Covered Members in accordance with prevailing professional standards, and in a manner similar to and within the same availability in which you provide dental services to any other individual.
- Dentist will provide the same levels of service and appointment availability for Covered Persons as for his/her other patients. Dentist agrees not to differentiate on the quality of service because of health status or payment source/Sponsor. Dentist shall offer the same appointment availability for all patients regardless of health status or payment source/Sponsor. Dentist shall not close the office to new patients due to health status or payment source/Sponsor.

It is the sole responsibility of the dentist to confirm eligibility prior to treating Covered Members. A dental office is strongly encouraged to confirm if they are participating with the member's dental plan so when recommending a treatment plan and cost of treatment it will reduce the risk of miscommunication and dissatisfaction between all parties.

Responsibilities of the Member

Depending on a member's oral health circumstance, the dental plan may or may not cover all of his or her treatment needs. The member's coverage level is not to be the sole determinant of the dental treatment recommended or provided. Members are responsible for:

- Choosing a participating or non-participating dentist;
- Providing a current identification card at each dental visit;
- Discussing, understanding and agreeing with treatment options and costs with their dentist prior to treatment; and
- Understanding their dental plan and be familiar with the dental benefits covered by their dental program. (Encourage members to call Customer Service if they have questions about coverage.)

Responsibilities of Anthem or Affiliates or Self-Funded Groups (may use Third Party Administrators) or National GRID program

Anthem or affiliates, self- funded groups (who may use Third Party Administrators) or National GRID program are responsible for administering the dental plan, making appropriate payments according to the dental plan benefits and maintaining the integrity of our various dental networks. Anthem or affiliates, self-funded groups (who may use Third Party Administrators), or National GRID program's obligations are to:

- Process submitted, "clean" dental claims correctly;
- Make payment directly to your office when the dentist is participating in the network that services a member's benefit plan; and
- Help the member and dental office understand the different benefit plans.

How to Contact Anthem Blue Cross Blue Shield

Provider Network Representative Services

Call dental Professional Services for questions regarding:

- All Anthem provider contracts
- Provider participation
- Fees
- Updating dentist and dental office information (address change, Tax ID number change, etc.)
- Escalated provider issues that cannot be resolved through Customer Service
- Provider Network Representative Services may also be contacted for questions related to **GRID** or **GRID+**

Provider Network Representative Services can be reached at **1-866-947-9398.**
Representatives are available Monday – Friday from 7:00am to 6:30pm CST

Updated dentist and dental office information may be emailed, faxed, or mailed to:

Email: **DentalNetworkSubmit@Anthem.com**

Fax: **1-877-283-1331**

Mail: Anthem Blue Cross and Blue Shield
Dental Professional Services
PO Box 640
Minneapolis, MN 55440

How to Contact Anthem Blue Cross Blue Shield, cont.

Customer Service

Prime and Complete Products/Networks

Please refer to the back of the member's ID card to verify the correct phone number and claims address. Customer Service is available Monday – Friday from 8:00am to 5:00pm in your local time zone.

<table>
<tr><th>State</th><th>Phone Number</th><th>Claims Address</th><th>Appeals Address</th></tr>
<tr><td>Colorado</td><td>855-769-1467</td><td rowspan="3">Anthem Dental Claims
PO Box 1115
Minneapolis, MN 55440-1115</td><td rowspan="13">Anthem
Attn: Appeals
PO Box 1122
Minneapolis, MN 55440-1122</td></tr>
<tr><td>Connecticut</td><td>866-956-8604</td></tr>
<tr><td>Georgia</td><td>877-604-2158</td></tr>
<tr><td>Indiana</td><td>877-604-2142</td><td>Anthem Dental Claims
PO Box 188
Minneapolis, MN 55440-0188</td></tr>
<tr><td>Kentucky</td><td>855-769-1464</td><td rowspan="9">Anthem Dental Claims
PO Box 1115
Minneapolis, MN 55440-1115</td></tr>
<tr><td>Maine</td><td>877-567-1757</td></tr>
<tr><td>Missouri</td><td>855-769-1465</td></tr>
<tr><td>Nevada</td><td>855-769-1462</td></tr>
<tr><td>New Hampshire</td><td>877-567-1806</td></tr>
<tr><td>Ohio</td><td>877-604-2156</td></tr>
<tr><td>Virginia</td><td>866-956-8607</td></tr>
<tr><td>Wisconsin</td><td>877-567-1805</td></tr>
</table>

Anthem Web Site – https://www.anthem.com/provider/dental/

How to Contact Anthem Blue Cross Blue Shield, cont.

Customer Service

Other Anthem PPO Products

Please refer to the back of the member's ID card. You may call 1-800-627-0004.

Customer Service is available Monday - Friday from 8:00am to 5:00pm in your local time zone.

Claims Address

Please refer to the back of the member's ID card to verify the correct claims address.

Other Anthem PPO Claims:
Anthem Dental
PO Box 659444
San Antonio, TX 78265

Electronic Claims Payer ID numbers are available from your clearinghouse.

Appeals/Written Correspondence Address

Other Anthem PPO products:
Anthem Blue Cross Blue Shield
Attn: Appeals – First Level Appeal Review
PO Box 659471
San Antonio, TX 78265

Anthem Web Site – https://www.anthem.com/provider/dental/

How to Contact Anthem Blue Cross Blue Shield, cont.

Federal Employee Program (FEP)

Customer Service

Please refer to the back of the member's ID card to verify the correct phone number and claims address. Claims are processed by FEP and cannot be accessed by Anthem.

State	Phone Number	Hours of Operation
Colorado	1-800-852-5957	M, T, W, F: 7:00 AM – 5:00 PM (Pacific) TH: 7:00 AM - 4:00 PM (Pacific)
Connecticut	1-800-438-5356	M, T, W, F: 8:00 AM – 5:30 PM (Eastern) TH: 9:00 AM - 5:30 PM (Eastern)
Georgia	1-800-282-2473	M, T, W, F: 8:00 AM – 5:30 PM (Eastern) TH: 8:00 AM-9:00AM, 10:00AM- 5:30 PM
Indiana	1-800-382-5520	M, T, W, F: 8:00 AM – 5:30 PM (Eastern) TH: 9:00 AM - 5:30 PM (Eastern)
Kentucky	1-800-456-3967	M, T, W, F: 8:00 AM – 5:30 PM (Eastern) TH: 9:00 AM - 5:30 PM (Eastern)
Maine	1-800-567-1832 (Provider) 1-800-722-0203	M, T, W, F: 8:00 AM – 5:30 PM (Eastern) TH: 9:00 AM - 5:30 PM (Eastern)
Missouri	1-800-392-8043	M, T, W, F: 8:00 AM – 5:30 PM (Eastern) TH: 9:00 AM - 5:30 PM (Eastern)
Nevada	1-800-727-4060	M, T, W, F: 7:00 AM – 5:00 PM (Pacific) TH: 7:00 AM - 4:00 PM (Pacific)
New Hampshire	1-800-852-3316	M, T, W, F: 8:00 AM – 5:30 PM (Eastern) TH: 9:00 AM - 5:30 PM (Eastern)
Ohio	1-800-451-7602	M, T, W, F: 8:00 AM – 5:30 PM (Eastern) TH: 9:00 AM - 5:30 PM (Eastern)
Virginia	1-800-552-6989 1-800-698-0418	M, T, W, F: 8:00 AM – 5:30 PM (Eastern) TH: 9:00 AM - 5:30 PM (Eastern)
Wisconsin	1-800-242-9635	M, T, W, F: 8:00 AM – 5:30 PM (Eastern) TH: 9:00 AM - 5:30 PM (Eastern)

Claims Address

Claims are processed by FEP and cannot be accessed by Anthem. Please refer to the back of the member's ID card to verify the correct claims address. In the absence of an address, please submit claims to:

Anthem Blue Cross and Blue Shield
Federal Employee Program (FEP)
P.O. Box 105557
Atlanta, GA 30348-5557

Appeals/Written Correspondence Address

Claims and appeals are processed by FEP and cannot be accessed by Anthem. Please contact FEP Customer Service for questions about claims and how to submit an appeal.

Provider Networks and Plans/Products

Section 2:

Please refer to the applicable state section for the state(s) in which you practice. Dentists participating in Anthem's dental networks do not need to sign an agreement for every state. If you practice in multiple states please contact dental Professional Services for assistance in determining if additional signed agreements are required.

Colorado Provider Networks

All dentists who have signed a Participation Agreement for Anthem's PPO 100/200/300/Prime/Complete, Discount Program, Anthem Blue Dental PPO, PPO Plus and Federal Employee Program networks are considered participating dentists to provide in network benefits to members.

Dental plan payments are made directly to a participating dentist. Payments are subject to the limitations, exclusions, deductibles, co-payments, and annual maximums of the member's dental benefit plan.

Anthem evaluates the allowances, under the member's dental plan, which may be made toward such treatment in accordance with covered benefits under the group contract, and the standards of generally accepted dental practices. Anthem does not interfere with the dentist's diagnosis or treatment plan.

The following pages include descriptions of the Anthem networks and the products they serve. Because there are different networks and coverage plans, it is extremely important that you ask a member for their identification card. Identification cards are not a guarantee of benefits or eligibility but will give you necessary information such as the type of plan, phone number to call for benefits and questions, as well as where to submit claims. Be sure to copy the front and the back of the member's identification card for future reference.

Traditional Provider Network

Anthem Blue Dental PPO and PPO Plus

The Anthem Blue Dental PPO and PPO Plus networks are established networks that have been in service for years. These networks are also referred to as our PPO and PPO Plus networks.

Any dentist who participates in the PPO and PPO Plus networks is also participating in the FEP network.

Federal Employee Program (FEP)

The FEP network covers active and retired Federal Employees and their families.

The FEP network contains:

- Basic Option
- Standard Option

Dentists that participate in FEP accept both Basic and Standard Option.

PPO 100/200/300/Prime/Complete

The PPO 100/200/300/Prime/Complete network is Anthem's newest network and is currently being marketed to commercial groups, ASO or fully insured employer groups and individuals.

General dentists may choose between three (3) levels of participation. Dentists choosing to participate in the 100/Prime/Complete level are also agreeing to participate in the 200/Complete and 300/Complete levels. Dentists choosing to participate in the 200/Complete level are also agreeing to participate in the 300/Complete level. Dentists choosing to participate in the 300/Complete level are only participating in the 300/Complete level.

Reimbursement is typically a combination of the plan payment and member payment that will equal up to the dentist's contracted allowed amount.

A specialist who participates in the Specialist network is considered participating in all three (3) levels and reimbursement is based on the specialist fee schedule.

Discount Program

The PPO 100/200/300/Prime/Complete Participating Dentist Agreement includes an addendum for those dentists that are interested in participating in the Discount Card Program. In order for a dentist to be eligible to participate in the Discount Card Program they must participate in the 200/Complete level and accept the 200/Complete fee schedule. The dentist must actively sign to participate in the Discount Card Program as the program has its own conditions for participation. It is typical for Discount Plans not to have any claims submitted to the plan for reimbursement as the payment for services rendered is received directly from the member at the dentist's contracted 200/Complete allowed amount at time of service. The dentist is responsible for requesting Discount Program identification material prior to providing services.

Dental Plans, Products or Dental Network Programs Using the PPO 100/200/300/Prime/Complete Networks

- **Dental Prime** = In-Network if participating in Colorado's PPO 100/Prime/Complete
- **Dental Complete** = In-Network if participating in Colorado's PPO100/Prime/Complete AND/OR PPO200/Complete AND/OR PPO300/Complete ONLY
- **Dental GRID** = In-Network if participating in Colorado's PPO100/Prime/Complete (Prime) as noted above
- **Dental GRID+** = In-Network if participating in Colorado's PPO100/Prime/Complete AND/OR PPO200/Complete and/or PPO300/Complete ONLY (Complete) as noted above
- **Dental Blue (DB) PPO100, PPO200, PPO300** = In-Network if participating in Colorado's PPO100/Prime/Complete and/or PPO200/Complete and/or PPO300/Complete ONLY

Note: Dental Plans/Products can have numerous designs as an employer can select what benefits they want to cover for their employees and at different percentage co-insurance levels (i.e. 100/80/50 – classic design)

GRID and GRID+

The national Dental GRID, administered by the GRID Dental Corporation, is one of the country's leading national dental networks.

The national Dental GRID offers customers and members of participating Blue Cross and Blue Shield plans a hassle-free opportunity to access more network dentists and discounts across the country.

This affiliation allows participating dentists to see members who were previously considered "out" of network as "in" network, with the plan payments going directly to the office rather than the member.

The national Dental GRID has two networks: GRID and GRID+.

GRID

- Access is available to Anthem Dental Prime members and members of other participating Blue Cross and Blue Shield Plans.
- Provider reimbursement is equivalent to Prime (PPO 100/Prime/Complete).
- Claims are processed "in" network when member is seen by a PPO 100/Prime/Complete dentist.
- Claims are processed "out" of network when member is seen by a PPO 200/Complete or PPO 300/Complete dentist.
- PPO 200/Complete or PPO 300/Complete dentist may balance bill the member up to their submitted fees.
- Specialists are in network for members who access GRID.

GRID+

- Access is available to Anthem Dental Complete members and members of other participating Blue Cross and Blue Shield Plans.
- Provider reimbursement is equivalent to Complete (PPO 100/Prime/Complete, PPO 200/Complete, and PPO 300/Complete).
- Member may be seen by any dentist who participates in PPO 100/Prime/Complete, PPO 200/Complete or PPO 300/Complete.

- Claims are processed at your contracted fee.
- Specialists are in network for members who access GRID+.

Identifying a Member Who Can Access the GRID or GRID+ Network

A participating plan will issue their own member ID cards indicating the plan name on the front of the card.

A member's ID card will have either GRID **or** GRID+ on the **back** of their card.

The Customer Service phone number of the participating plan and the Claims address of where to submit claims for these members will be on the back of the member's ID Card.

Member's coverage:

A participating plan's members receive in network benefits when being seen by dental providers outside of their local plan's service area when the plan participates in the GRID and the network level.

Claims Submission:

Claims are submitted to the plan's claims address, as listed on the back of the member's ID card.

Claims Payments:

Payments are made from the member's plan, directly to the treating dentist. The fee schedule used will be based on the treating doctor's location and participation in the 100/200/300/Prime/Complete networks.

The GRID Dental Corporation is a separate company that provides dental network services on behalf of Anthem Blue Cross and Blue Shield, an independent licensee of the Blue Cross and Blue Shield Association.

PPO 100/200/300/Prime/Complete Plans/Products

The chart below compares reimbursement for the provider networks (PPO 100/200/300/Prime/Complete and GRID/GRID+) that our members may access.

Provider Participation Network Level					
Member / Group / Product		**PPO100/Prime/Complete, PPO200/Complete, PPO300/Complete, & GRID & GRID+**	**PPO200/Complete, PPO300/Complete, & GRID+**	**PPO300/Complete, & GRID+**	**SPECIALIST, & GRID & GRID+**
	100	In Network Pays at and Collect up to 100/Prime/Complete Allowed Amount	In Network Pays at 100/Prime/Complete, Collect up to 200/Complete Allowed Amount	In Network Pays at 100/Prime/Complete, Collect up to 300/Complete Allowed Amount	In- Network Pays at and Collect up to Specialist Allowed Amount
	200	In Network Pays at and Collect up to 200/Complete Allowed Amount	In Network Pays at and Collect up to 200/Complete Allowed Amount	In Network Pays at 200/Complete, Collect up to 300/Complete Allowed Amount	In- Network Pays at and Collect up to Specialist Allowed Amount
	300	In Network Pays at and Collect up to 300/Complete Allowed Amount	In Network Pays at and Collect up to 300/Complete Allowed Amount	In Network Pays at and Collect up to 300/Complete Allowed Amount	In- Network Pays at and Collect up to Specialist Allowed Amount
	100/200/300	In Network Pays at and Collect up to 100/Prime/Complete Allowed Amount	In Network Pays at and Collect up to 200/Complete Allowed Amount	In Network Pays at and Collect up to 300/Complete Allowed Amount	In- Network Pays at and Collect up to Specialist Allowed Amount
	Dental Prime	In Network Pays at and Collect up to 100/Prime/Complete Allowed Amount	OUT OF NETWORK Balance Billing up to providers usual fee	OUT OF NETWORK Balance Billing up to providers usual fee	In- Network Pays at and Collect up to Specialist Allowed Amount
	Dental Complete	In Network Pays at and Collect up to 100/Prime/Complete Allowed Amount	In Network Pays at and Collect up to 200/Complete Allowed Amount	In Network Pays at and Collect up to 300/Complete Allowed Amount	In- Network Pays at and Collect up to Specialist Allowed Amount

Connecticut Provider Networks

All dentists who have signed a Participation Agreement for Anthem's PPO 100/200/300/Prime/Complete, Preventive/Preventive Plus, Flex, Full, Copayment or Federal Employee Program are considered participating dentists.

Dental plan payments are made directly to a participating dentist. Payments are subject to the limitations, exclusions, deductibles, co-payments, and annual maximums of the member's dental benefit plan.

Anthem evaluates the allowances under the member's dental plan, which may be made toward such treatment in accordance with covered benefits under the group contract, and the standards of generally accepted dental practices. Anthem does not interfere with the dentist's diagnosis or treatment plan.

Anthem dental PPO plans do not require a referral either within or outside the network. Members can select any provider they prefer.

The following pages include descriptions of the Anthem networks and the products they serve. Because there are different networks and coverage plans, it is extremely important that you ask members for their identification cards. Identification cards are not a guarantee of benefits or eligibility but will give you necessary information such as the type of plan, phone number to call for benefits and questions, as well as where to submit claims. Be sure to copy the front and the back of the member's identification card for future reference.

Traditional Provider Network

Preventive/Preventive Plus Network

The Preventive/Preventive Plus network is an established network that has been in service for years. It is a local network that is utilized by Connecticut-based Administrative Services Only (ASO) or fully insured employer groups. This network is also referred to as our PPO network.

The products serviced by this network are:

- Preventive
- Preventive Plus

Any dentist who participates in the Preventive/Preventive Plus network is also participating in the Flex, Full, Copayment network.

Flex, Full, Copayment Network

The Flex, Full, Copayment network is an established national network serving commercial groups, ASO or fully insured employer groups, self-funded labor groups and individuals. This network is also referred to as our PPO Plus network.

The products serviced by this network are:

- Flex Dental
- Full
- Copayment

Federal Employee Program (FEP)

The FEP network covers active and retired Federal Employees and their families.

The FEP network contains:

- Basic Option
- Standard Option

Dentists that participate in FEP accept both Basic and Standard Option. Dentists in FEP do not need to participate in the Preventive/Preventive Plus or Flex, Full, Copayment networks.

PPO 100/200/300/Prime/Complete

The PPO 100/200/300/Prime/Complete network is Anthem's newest network and is currently being marketed to commercial groups, ASO or fully insured employer groups and individuals.

General dentists may choose between three (3) levels of participation. Dentists choosing to participate in the 100/Prime/Complete level are also agreeing to participate in the 200/Prime/Complete and 300/Complete levels. Dentists choosing to participate in the 200/Prime/Complete level are also agreeing to participate in the 300/Complete level. Dentists choosing to participate in the 300/Complete level are only participating in the 300/Complete level.

Reimbursement is typically a combination of the plan payment and member payment that will equal up to the dentist's contracted allowed amount.

A specialist who participates in the Specialist network is considered participating in all three (3) levels and is reimbursed based on the specialist fee schedule.

Discount Program

The PPO 100/200/300/Prime/Complete Participating Dentist Agreement includes an addendum for those dentists that are interested in participating in the Discount Card Program. In order for a dentist to be eligible to participate in the Discount Card Program they must participate in the 200/Prime/Complete level and accept the 200/Prime/Complete fee schedule. The dentist must actively sign to participate in the Discount Card Program as the program has its own conditions for participation. It is typical for Discount Plans not to have any claims submitted to the plan for reimbursement as the payment for services rendered is received directly from the member at the dentist's contracted 200/Prime/Complete allowed amount at time of service. The dentist is responsible for requesting Discount Program identification material prior to providing services.

Dental Plans, Products or Dental Network Programs Using the PPO 100/200/300/Prime/Complete Networks

- **Dental Prime** = In-Network if participating in PPO 100/Prime/Complete AND/OR PPO 200/Prime/Complete
- **Dental Complete** = In-Network if participating in PPO 100/Prime/Complete AND/OR PPO 200/Prime/Complete AND/OR PPO 300/Complete ONLY
- **Dental GRID** = In-Network if participating in PPO 100/Prime/Complete AND/OR PPO 200/Prime/Complete
- **Dental GRID+** = In-Network if participating in PPO 100/Prime/Complete AND/OR PPO 200/Prime/Complete AND/OR PPO 300/Complete ONLY
- **Dental BLUE (DB) PPO100, PPO200, PPO300** = In-Network if participating in PPO 100/Prime/Complete AND/OR PPO 200/Prime/Complete AND/OR PPO 300/Complete ONLY

Note – Dental Plans/Products can have numerous designs as an employer can select what benefits they want to cover for their employees and at different percentage co-insurance levels (i.e. 100/80/50 – classic design)

GRID and GRID+

The national Dental GRID, administered by the GRID Dental Corporation, is one of the country's leading national dental networks.

The national Dental GRID offers customers of participating Blue Cross and Blue Shield plans a hassle-free opportunity to access more network dentists and discounts across the country.

This affiliation allows participating dentists to see members who were previously considered "out" of network as "in" network, with the plan payments going directly to the office rather than the member.

The national Dental GRID has two networks: GRID and GRID+.

GRID

- Access is available to Anthem Dental Prime members and members of other participating Blue Cross and Blue Shield Plans.
- Provider reimbursement is equivalent to Prime (PPO 100/Prime/Complete and PPO 200/Prime/Complete).
- Claims are processed "in" network when member is seen by a PPO 100/Prime/Complete or PPO 200/Prime/Complete dentist.
- Claims are processed "out" of network when member is seen by a PPO 300/Complete dentist.
    - PPO 300/Complete dentist may balance bill the member up to their submitted fees.
- Specialists are in network for members who access GRID.

GRID+

- Access is available to Anthem Dental Complete members and members of other participating Blue Cross and Blue Shield Plans.
- Provider reimbursement is equivalent to Complete (PPO 100/Prime/Complete, PPO 200/Prime/Complete, and PPO 300/Complete).
- Member may be seen by any dentist who participates in PPO 100/Prime/Complete, PPO 200/Prime/Complete or PPO 300/Complete.
- Claims are processed at your contracted fee.
- Specialists are in network for members who access GRID+.

Identifying a Member Who Can Access the GRID or GRID+ Network

- A participating plan will issue their own member ID cards indicating the plan name on the front of the card.
- A member's ID card will have either GRID **or** GRID+ on the **back** of their card.
- The Customer Service phone number of the participating plan and the Claims address of where to submit claims for these members will be on the back of the member's ID Card.

Member's coverage:

A participating plan's members receive in network benefits when being seen by dental providers outside of their local plan's service area when the plan participates in the GRID and the network level.

Claims Submission:

Claims are submitted to the plan's claims address, as listed on the back of the member's ID card.

Claims Payments:

Payments are made from the member's plan, directly to the treating dentist. The fee schedule used will be based on the treating doctor's location and participation in the PPO 100/200/300/Prime/Complete networks.

The GRID Dental Corporation is a separate company that provides dental network services on behalf of Anthem Blue Cross and Blue Shield, an independent licensee of the Blue Cross and Blue Shield Association

PPO 100/200/300/Prime/Complete Plans/Products

The chart below compares reimbursement for the provider networks (PPO 100/200/300/Prime/Complete and GRID/GRID+) that our members may access.

Provider Participation Network Level					
Member / Group / Product		**PPO100/Prime/Complete, PPO200/Prime/Complete, PPO300/Complete, & GRID & GRID+**	**PPO200/Prime/Complete, PPO300/Complete, & GRID & GRID+**	**PPO300/Complete, & GRID+**	**SPECIALIST, & GRID & GRID+**
	100	In Network Pays at and Collect up to 100/Prime/Complete Allowed Amount	In Network Pays at 100/Prime/Complete, Collect up to 200/Prime/Complete Allowed Amount	In Network Pays at 100/Prime/Complete, Collect up to 300/Complete Allowed Amount	In- Network Pays at and Collect up to Specialist Allowed Amount
	200	In Network Pays at and Collect up to 200/Prime/Complete Allowed Amount	In Network Pays at and Collect up to 200/Prime/Complete Allowed Amount	In Network Pays at 200/Prime/Complete, Collect up to 300/Complete Allowed Amount	In- Network Pays at and Collect up to Specialist Allowed Amount
	300	In Network Pays at and Collect up to 300/Complete Allowed Amount	In Network Pays at and Collect up to 300/Complete Allowed Amount	In Network Pays at and Collect up to 300/Complete Allowed Amount	In- Network Pays at and Collect up to Specialist Allowed Amount
	100/200/300	In Network Pays at and Collect up to 100/Prime/Complete Allowed Amount	In Network Pays at and Collect up to 200/Prime/Complete Allowed Amount	In Network Pays at and Collect up to 300/Complete Allowed Amount	In- Network Pays at and Collect up to Specialist Allowed Amount
	Dental Prime	In Network Pays at and Collect up to 100/Prime/Complete Allowed Amount	In Network Pays at and Collect up to 200/Prime/Complete Allowed Amount	OUT OF NETWORK Balance Billing up to providers usual fee	In- Network Pays at and Collect up to Specialist Allowed Amount
	Dental Complete	In Network Pays at and Collect up to 100/Prime/Complete Allowed Amount	In Network Pays at and Collect up to 200/Prime/Complete Allowed Amount	In Network Pays at and Collect up to 300/Complete Allowed Amount	In- Network Pays at and Collect up to Specialist Allowed Amount

Georgia Provider Networks

All dentists who have signed a Participation Agreement for Anthem's PPO 100/200/300/Prime/Complete, Discount Program, Anthem PPO, SmileNet and Federal Employee Program networks are considered participating dentists to provide in network benefits to members.

Dental plan payments are made directly to a participating dentist. Payments are subject to the limitations, exclusions, deductibles, co-payments, and annual maximums of the member's dental benefit plan.

Anthem evaluates the allowances, under the member's dental plan, which may be made toward such treatment in accordance with covered benefits under the group contract, and the standards of generally accepted dental practices. Anthem does not interfere with the dentist's diagnosis or treatment plan.

The following pages include descriptions of the Anthem networks and the products they serve. Because there are different networks and coverage plans, it is extremely important that you ask a member for their identification card. Identification cards are not a guarantee of benefits or eligibility but will give you necessary information such as the type of plan, phone number to call for benefits and questions, as well as where to submit claims. Be sure to copy the front and the back of the member's identification card for future reference.

Traditional Provider Network

Anthem PPO

The Anthem Traditional network is an established network that has been in service for years. This network is also referred to as our Traditional network.

Any dentist who participates in the Anthem Traditional network is also participating in the SmileNet Dental Discount Plan, Basic Option FEP network and has the option to also participate in the Standard Option FEP network.

SmileNet Dental Discount Plan

The Traditional network includes participation in the SmileNet Dental Discount Plan.

SmileNet does not require claim submission for reimbursement nor does it have any plan restrictions, limitations or exclusions.

Covered Persons under the Dental Discount Plan will be responsible for payment directly to the Participating Dentist of the lesser of: (i) the Participating Dentist's usual charge, or (ii) the amount shown in the current fee schedule (the "Reimbursement Amount") which is attached to the in force Participating Provider Agreement.

The dentist is responsible for requesting SmileNet identification material prior to providing services.

Federal Employee Program (FEP)

The FEP network covers active and retired Federal Employees and their families.

The FEP network contains:

- Basic Option (included when participating in the Anthem Traditional Network)
- Standard Option (Optional Network)

PPO 100/200/300/Prime/Complete

The PPO 100/200/300/Prime/Complete network is Anthem's newest network and is currently being marketed to commercial groups, ASO or fully insured employer groups and individuals.

General dentists may choose between three (3) levels of participation. Dentists choosing to participate in the 100/Prime/Complete level are also agreeing to participate in the 200/Prime/Complete and 300/Complete levels. Dentists choosing to participate in the 200/Prime/Complete level are also agreeing to participate in the 300/Complete level. Dentists choosing to participate in the 300/Complete level are only participating in the 300/Complete level.

Reimbursement is typically a combination of the plan payment and member payment that will equal up to the dentist's contracted allowed amount.

A specialist who participates in the Specialist network is considered participating in all three (3) levels and reimbursement is based on the specialist fee schedule.

Discount Program

The PPO 100/200/300/Prime/Complete Participating Dentist Agreement includes an addendum for those dentists that are interested in participating in the Discount Card Program. In order for a dentist to be eligible to participate in the Discount Card Program they must participate in the 200/Prime/Complete level and accept the 200/Prime/Complete fee schedule. The dentist must actively sign to participate in the Discount Card Program as the program has its own conditions for participation. It is typical for Discount Plans not to have any claims submitted to the plan for reimbursement as the payment for services rendered is received directly from the member at the dentist's contracted 200/Prime/Complete allowed amount at time of service. The dentist is responsible for requesting Discount Program identification material prior to providing services.

Dental Plans, Products or Dental Network Programs Using the PPO 100/200/300/Prime/Complete Networks

- **Dental Prime** = In-Network if participating in Georgia's PPO 100/Prime/Complete AND/OR PPO 200/Prime/Complete
- **Dental Complete** = In-Network if participating in Georgia's PPO 100/Prime/Complete AND/OR PPO 200/Prime/Complete AND/OR PPO 300/Complete ONLY
- **Dental GRID** = In-Network if participating in Georgia's PPO100/Prime/Complete AND/OR 200/Prime/Complete (Prime) as noted above
- **Dental GRID+** = In-Network if participating in Georgia's PPO 100/Prime/Complete AND/OR PPO200/Prime/Complete and/or PPO 300/Complete ONLY (Complete) as noted above
- **Dental Blue (DB) PPO100, PPO200, PPO300** = In-Network if participating in Georgia's PPO100/Prime/Complete and/or PPO 200/Prime/Complete and/or PPO 300/Complete ONLY

Note: Dental Plans/Products can have numerous designs as an employer can select what benefits they want to cover for their employees and at different percentage co-insurance levels (i.e. 100/80/50 – classic design)

GRID and GRID+

The national Dental GRID, administered by the GRID Dental Corporation, is one of the country's leading national dental networks.

The national Dental GRID offers customers and members of participating Blue Cross and Blue Shield plans a hassle-free opportunity to access more network dentists and discounts across the country.

This affiliation allows participating dentists to see members who were previously considered "out" of network as "in" network, with the plan payments going directly to the office rather than the member.

The national Dental GRID has two networks: GRID and GRID+.

GRID

- Access is available to Anthem Dental Prime members and members of other participating Blue Cross and Blue Shield Plans.
- Provider reimbursement is equivalent to Prime (PPO 100/Prime/Complete or PPO 200/Prime/Complete).
- Claims are processed "in" network when member is seen by a PPO 100/Prime/Complete or PPO 200/Prime/Complete dentist.

- Claims are processed "out" of network when member is seen by a PPO 300/Complete dentist.
  - PPO 300/Complete dentists may balance bill the member up to their submitted fees.
- Specialists are in network for members who access GRID.

GRID+

- Access is available to Anthem Dental Complete members and members of other participating Blue Cross and Blue Shield Plans.
- Provider reimbursement is equivalent to Complete (PPO 100/Prime/Complete, PPO 200/Prime/Complete, and PPO 300/Complete).
- Member may be seen by any dentist who participates in PPO 100/Prime/Complete, PPO 200/Prime/Complete or PPO 300/Complete.
- Claims are processed at your contracted fee.
- Specialists are in network for members who access GRID+.

Identifying a Member Who Can Access the GRID or GRID+ Network

A participating plan will issue their own member ID cards indicating the plan name on the front of the card.

A member's ID card will have either GRID **or** GRID+ on the **back** of their card.

The Customer Service phone number of the participating plan and the Claims address of where to submit claims for these members will be on the back of the member's ID Card.

Member's coverage:

A participating plan's members receive in network benefits when being seen by dental providers outside of their local plan's service area when the plan participates in the GRID and the network level.

Claims Submission:

Claims are submitted to the plan's claims address, as listed on the back of the member's ID card.

Claims Payments:

Payments are made from the member's plan, directly to the treating dentist. The fee schedule used will be based on the treating doctor's location and participation in the PPO100/200/300/Prime/Complete networks.

The GRID Dental Corporation is a separate company that provides dental network services on behalf of Anthem Blue Cross and Blue Shield, an independent licensee of the Blue Cross and Blue Shield Association.

PPO 100/200/300/Prime/Complete Plans/Products

The chart below compares reimbursement for the provider networks (PPO 100/200/300/Prime/Complete and GRID/GRID+) that our members may access.

Provider Participation Network Level					
Member / Group / Product		**PPO100/Prime/Complete, PPO200/Prime/Complete, PPO300/Complete, & GRID & GRID+**	**PPO200/Prime/Complete, PPO300/Complete, & GRID & GRID+**	**PPO300/Complete, & GRID+**	**SPECIALIST, & GRID & GRID+**
	100	In Network Pays at and Collect up to 100/Prime/Complete Allowed Amount	In Network Pays at 100/Prime/Complete, Collect up to 200/Prime/Complete Allowed Amount	In Network Pays at 100/Prime/Complete, Collect up to 300/Complete Allowed Amount	In- Network Pays at and Collect up to Specialist Allowed Amount
	200	In Network Pays at and Collect up to 200/Prime/Complete Allowed Amount	In Network Pays at and Collect up to 200/Prime/Complete Allowed Amount	In Network Pays at 200/Prime/Complete, Collect up to 300/Complete Allowed Amount	In- Network Pays at and Collect up to Specialist Allowed Amount
	300	In Network Pays at and Collect up to 300/Complete Allowed Amount	In Network Pays at and Collect up to 300/Complete Allowed Amount	In Network Pays at and Collect up to 300/Complete Allowed Amount	In- Network Pays at and Collect up to Specialist Allowed Amount
	100/200/300	In Network Pays at and Collect up to 100/Prime/Complete Allowed Amount	In Network Pays at and Collect up to 200/Prime/Complete Allowed Amount	In Network Pays at and Collect up to 300/Complete Allowed Amount	In- Network Pays at and Collect up to Specialist Allowed Amount
	Dental Prime	In Network Pays at and Collect up to 100/Prime/Complete Allowed Amount	In Network Pays at and Collect up to 200/Prime/Complete Allowed Amount	OUT OF NETWORK Balance Billing up to providers usual fee	In- Network Pays at and Collect up to Specialist Allowed Amount
	Dental Complete	In Network Pays at and Collect up to 100/Prime/Complete Allowed Amount	In Network Pays at and Collect up to 200/Prime/Complete Allowed Amount	In Network Pays at and Collect up to 300/Complete Allowed Amount	In- Network Pays at and Collect up to Specialist Allowed Amount

Indiana Provider Networks

All dentists who have signed a Participation Agreement for Anthem's PPO 100/200/300/Prime/Complete, Discount Program, Anthem Dental PPO, and Federal Employee Program networks are considered participating dentists to provide in network benefits to members.

Dental plan payments are made directly to a participating dentist. Payments are subject to the limitations, exclusions, deductibles, co-payments, and annual maximums of the member's dental benefit plan.

Anthem evaluates the allowances, under the member's dental plan, which may be made toward such treatment in accordance with covered benefits under the group contract, and the standards of generally accepted dental practices. Anthem does not interfere with the dentist's diagnosis or treatment plan.

The following pages include descriptions of the Anthem networks and the products they serve. Because there are different networks and coverage plans, it is extremely important that you ask a member for their identification card. Identification cards are not a guarantee of benefits or eligibility but will give you necessary information such as the type of plan, phone number to call for benefits and questions, as well as where to submit claims. Be sure to copy the front and the back of the member's identification card for future reference.

Traditional Provider Network

Anthem Dental PPO

The Anthem Dental PPO network is an established network that has been in service for years. This network is also referred to as our Traditional PPO network.

Any dentist who participates in the PPO network is also participating in the FEP network.

Federal Employee Program (FEP)

The FEP network covers active and retired Federal Employees and their families.

The FEP network contains:

- Basic Option
- Standard Option

Dentists that participate in FEP accept both Basic and Standard Option.

PPO 100/200/300/Prime/Complete

The PPO 100/200/300/Prime/Complete network is Anthem's newest network and is currently being marketed to commercial groups, ASO or fully insured employer groups and individuals.

General dentists may choose between three (3) levels of participation. Dentists choosing to participate in the 100/Prime/Complete level are also agreeing to participate in the 200/Prime/Complete and 300/Complete levels. Dentists choosing to participate in the 200/Prime/Complete level are also agreeing to participate in the 300/Complete level. Dentists choosing to participate in the 300/Complete level are only participating in the 300/Complete level.

Reimbursement is typically a combination of the plan payment and member payment that will equal up to the dentist's contracted allowed amount.

A specialist who participates in the Specialist network is considered participating in all three (3) levels and reimbursement is based on the specialist fee schedule.

Discount Program

The PPO 100/200/300/Prime/Complete Participating Dentist Agreement includes an addendum for those dentists that are interested in participating in the Discount Card Program. In order for a dentist to be eligible to participate in the Discount Card Program they must participate in the 200/Prime/Complete level and accept the 200/Prime/Complete fee schedule. The dentist must actively sign to participate in the Discount Card Program as the program has its own conditions for participation. It is typical for Discount Plans not to have any claims submitted to the plan for reimbursement as the payment for services rendered is received directly from the member at the dentist's contracted 200/Prime/Complete allowed amount at time of service. The dentist is responsible for requesting Discount Program identification material prior to providing services.

Dental Plans, Products or Dental Network Programs Using the PPO 100/200/300/Prime/Complete Networks

- **Dental Prime** = In-Network if participating in Indiana's PPO100/Prime/Complete AND/OR PPO 200/Prime/Complete
- **Dental Complete** = In-Network if participating in Indiana's PPO 100/Prime/Complete AND/OR PPO 200/Prime/Complete AND/OR PPO 300/Complete ONLY

- **Dental GRID** = In-Network if participating in Indiana's PPO 100/Prime/Complete AND/OR PPO 200/Prime/Complete (Prime) as noted above
- **Dental GRID+** = In-Network if participating in Indiana's PPO100/Prime/Complete AND/OR PPO 200/Prime/Complete AND/OR PPO 300/Complete ONLY (Complete) as noted above
- **Dental Blue (DB) PPO100, PPO200, PPO300** = In-Network if participating in Indiana's PPO 100/Prime/Complete AND/OR PPO 200/Prime/Complete AND/OR PPO 300/Complete ONLY

Note: Dental Plans/Products can have numerous designs as an employer can select what benefits they want to cover for their employees and at different percentage co-insurance levels (i.e. 100/80/50 – classic design)

GRID and GRID+

The national Dental GRID, administered by the GRID Dental Corporation, is one of the country's leading national dental networks.

The national Dental GRID offers customers and members of participating Blue Cross and Blue Shield plans a hassle-free opportunity to access more network dentists and discounts across the country.

This affiliation allows participating dentists to see members who were previously considered "out" of network as "in" network, with the plan payments going directly to the office rather than the member.

The national Dental GRID has two networks: GRID and GRID+.

GRID

- Access is available to Anthem Dental Prime members and members of other participating Blue Cross and Blue Shield Plans.
- Provider reimbursement is equivalent to Prime (PPO 100/Prime/Complete or PPO 200/Prime/Complete).
- Claims are processed "in" network when member is seen by a PPO 100/Prime/Complete or PPO 200/Prime/Complete dentist.
- Claims are processed "out" of network when member is seen by a PPO 300/Complete dentist.
- PPO 300/Complete dentists may balance bill the member up to their submitted fees.
- Specialists are in network for members who access GRID.

GRID+

- Access is available to Anthem Dental Complete members and members of other participating Blue Cross and Blue Shield Plans.
- Provider reimbursement is equivalent to Complete (PPO 100/Prime/Complete, PPO 200/Prime/Complete, and PPO 300/Complete).
- Member may be seen by any dentist who participates in PPO 100/Prime/Complete, PPO 200/Prime/Complete or PPO 300/Complete.
- Claims are processed at your contracted fee.
- Specialists are in network for members who access GRID+.

Identifying a Member Who Can Access the GRID or GRID+ Network

- A participating plan will issue their own member ID cards indicating the plan name on the front of the card.
- A member's ID card will have either GRID or GRID+ on the back of their card.

- The Customer Service phone number of the participating plan and the Claims address of where to submit claims for these members will be on the back of the member's ID Card.

Member's coverage:

A participating plan's members receive in network benefits when being seen by dental providers outside of their local plan's service area when the plan participates in the GRID and the network level.

Claims Submission:

Claims are submitted to the plan's claims address, as listed on the back of the member's ID card.

Claims Payments:

Payments are made from the member's plan, directly to the treating dentist. The fee schedule used will be based on the treating doctor's location and participation in the PPO 100/200/300/Prime/Complete networks.

The GRID Dental Corporation is a separate company that provides dental network services on behalf of Anthem Blue Cross and Blue Shield, an independent licensee of the Blue Cross and Blue Shield Association.

PPO 100/200/300/Prime/Complete Plans/Products

The chart below compares reimbursement for the provider networks (PPO 100/200/300/Prime/Complete and GRID/GRID+) that our members may access.

Provider Participation Network Level					
Member / Group / Product		**PPO100/Prime/Complete, PPO200/Prime/Complete, PPO300/Complete, & GRID & GRID+**	**PPO200/Prime/Complete, PPO300/Complete, & GRID & GRID+**	**PPO300/Complete, & GRID+**	**SPECIALIST, & GRID & GRID+**
	100	In Network Pays at and Collect up to 100/Prime/Complete Allowed Amount	In Network Pays at 100/Prime/Complete, Collect up to 200/Prime/Complete Allowed Amount	In Network Pays at 100/Prime/Complete, Collect up to 300/Complete Allowed Amount	In- Network Pays at and Collect up to Specialist Allowed Amount
	200	In Network Pays at and Collect up to 200/Prime/Complete Allowed Amount	In Network Pays at and Collect up to 200/Prime/Complete Allowed Amount	In Network Pays at 200/Prime/Complete, Collect up to 300/Complete Allowed Amount	In- Network Pays at and Collect up to Specialist Allowed Amount
	300	In Network Pays at and Collect up to 300/Complete Allowed Amount	In Network Pays at and Collect up to 300/Complete Allowed Amount	In Network Pays at and Collect up to 300/Complete Allowed Amount	In- Network Pays at and Collect up to Specialist Allowed Amount
	100/200/300	In Network Pays at and Collect up to 100/Prime/Complete Allowed Amount	In Network Pays at and Collect up to 200/Prime/Complete Allowed Amount	In Network Pays at and Collect up to 300/Complete Allowed Amount	In- Network Pays at and Collect up to Specialist Allowed Amount
	Dental Prime	In Network Pays at and Collect up to 100/Prime/Complete Allowed Amount	In Network Pays at and Collect up to 200/Prime/Complete Allowed Amount	OUT OF NETWORK Balance Billing up to providers usual fee	In- Network Pays at and Collect up to Specialist Allowed Amount
	Dental Complete	In Network Pays at and Collect up to 100/Prime/Complete Allowed Amount	In Network Pays at and Collect up to 200/Prime/Complete Allowed Amount	In Network Pays at and Collect up to 300/Complete Allowed Amount	In- Network Pays at and Collect up to Specialist Allowed Amount

Kentucky Provider Networks

All dentists who have signed a Participation Agreement for Anthem's PPO 100/200/300/Prime/Complete, Discount Program, Anthem Dental PPO, and Federal Employee Program networks are considered participating dentists to provide in network benefits to members.

Dental plan payments are made directly to a participating dentist. Payments are subject to the limitations, exclusions, deductibles, co-payments, and annual maximums of the member's dental benefit plan.

Anthem evaluates the allowances, under the member's dental plan, which may be made toward such treatment in accordance with covered benefits under the group contract, and the standards of generally accepted dental practices. Anthem does not interfere with the dentist's diagnosis or treatment plan.

The following pages include descriptions of the Anthem networks and the products they serve. Because there are different networks and coverage plans, it is extremely important that you ask a member for their identification card. Identification cards are not a guarantee of benefits or eligibility but will give you necessary information such as the type of plan, phone number to call for benefits and questions, as well as where to submit claims. Be sure to copy the front and the back of the member's identification card for future reference.

Traditional Provider Network

Anthem Dental PPO

The Anthem Dental PPO network is an established network that has been in service for years. This network is also referred to as our Traditional PPO network.

Any dentist who participates in the PPO network is also participating in the FEP network.

Federal Employee Program (FEP)

The FEP network covers active and retired Federal Employees and their families.

The FEP network contains:

- Basic Option
- Standard Option

Dentists that participate in FEP accept both Basic and Standard Option.

PPO100/200/300/Prime/Complete

The PPO 100/200/300/Prime/Complete network is Anthem's newest network and is currently being marketed to commercial groups, ASO or fully insured employer groups and individuals.

General dentists may choose between three (3) levels of participation. Dentists choosing to participate in the 100/Prime/Complete level are also agreeing to participate in the 200/Complete and 300/Complete levels. Dentists choosing to participate in the 200/Complete level are also agreeing to participate in the 300/Complete level. Dentists choosing to participate in the 300/Complete level are only participating in the 300/Complete level.

Reimbursement is typically a combination of the plan payment and member payment that will equal up to the dentist's contracted allowed amount.

A specialist who participates in the Specialist network is considered participating in all three (3) levels and is reimbursed based on the specialist fee schedule.

Discount Program

The PPO 100/200/300/Prime/Complete Participating Dentist Agreement includes an addendum for those dentists that are interested in participating in the Discount Card Program. In order for a dentist to be eligible to participate in the Discount Card Program they must participate in the 200/Complete level and accept the 200/Complete fee schedule. The dentist must actively sign to participate in the Discount Card Program as the program has its own conditions for participation. It is typical for Discount Plans not to have any claims submitted to the plan for reimbursement as the payment for services rendered is received directly from the member at the dentist's contracted 200/Complete allowed amount at time of service. The dentist is responsible for requesting Discount Program identification material prior to providing services.

Dental Plans, Products or Dental Network Programs Using the PPO 100/200/300/Prime/Complete Networks

- **Dental Prime =** In-Network if participating in Kentucky's PPO 100/Prime/Complete
- **Dental Complete** = In-Network if participating in Kentucky's PPO 100/Prime/Complete AND/OR PPO 200/Complete AND/OR PPO 300/Complete ONLY
- **Dental GRID** = In-Network if participating in Kentucky's PPO 100/Prime/Complete (Prime) as noted above
- **Dental GRID+** = In-Network if participating in Kentucky's PPO 100/Prime/Complete AND/OR PPO 200/Complete AND/OR PPO 300/Complete ONLY (Complete) as noted above
- **Dental Blue (DB) PPO100, PPO200, PPO300** = In-Network if participating in Kentucky's PPO 100/Prime/Complete AND/OR PPO 200/Complete AND/OR PPO 300/Complete ONLY

Note: Dental Plans/Products can have numerous designs as an employer can select what benefits they want to cover for their employees and at different percentage co-insurance levels (i.e. 100/80/50 – classic design)

GRID and GRID+

The national Dental GRID, administered by the GRID Dental Corporation, is one of the country's leading national dental networks.

The national Dental GRID offers customers and members of participating Blue Cross and Blue Shield plans a hassle-free opportunity to access more network dentists and discounts across the country.

This affiliation allows participating dentists to see members who were previously considered "out" of network as "in" network, with the plan payments going directly to the office rather than the member.

The national Dental GRID has two networks: GRID and GRID+.

GRID

- Access is available to Anthem Dental Prime members and members of other participating Blue Cross and Blue Shield Plans.
- Provider reimbursement is equivalent to Prime (PPO 100/Prime/Complete).
- Claims are processed "in" network when member is seen by a PPO 100/Prime/Complete dentist.
- Claims are processed "out" of network when member is seen by a PPO 200/Complete or PPO 300/Complete dentist.
    - PPO 200/Complete or PPO 300/Complete dentist may balance bill the member up to their submitted fees.
- Specialists are in network for members who access GRID.

GRID+

- Access is available to Anthem Dental Complete members and members of other participating Blue Cross and Blue Shield Plans.
- Provider reimbursement is equivalent to Complete (PPO 100/Prime/Complete, PPO 200/Complete, and PPO 300/Complete).

- Member may be seen by any dentist who participates in PPO 100/Prime/Complete, PPO 200/Complete or PPO 300/Complete.
- Claims are processed at your contracted fee.
- Specialists are in network for members who access GRID+.

Identifying a Member Who Can Access the GRID or GRID+ Network

- A participating plan will issue their own member ID cards indicating the plan name on the front of the card.
- A member's ID card will have either GRID **or** GRID+ on the **back** of their card.

The Customer Service phone number of the participating plan and the Claims address of where to submit claims for these members will be on the back of the member's ID Card.

Member's coverage:

A participating plan's members receive in network benefits when being seen by dental providers outside of their local plan's service area when the plan participates in the GRID and the network level.

Claims Submission:

Claims are submitted to the plan's claims address, as listed on the back of the member's ID card.

Claims Payments:

Payments are made from the member's plan, directly to the treating dentist. The fee schedule used will be based on the treating doctor's location and participation in the PPO 100/200/300/Prime/Complete networks.

The GRID Dental Corporation is a separate company that provides dental network services on behalf of Anthem Blue Cross and Blue Shield, an independent licensee of the Blue Cross and Blue Shield Association.

PPO 100/200/300/Prime/Complete Plans/Products

The chart below compares reimbursement for the provider networks (PPO 100/200/300/Prime/Complete and GRID/GRID+) that our members may access.

Provider Participation Network Level					
Member / Group / Product		**PPO100/Prime/Complete, PPO200/Complete, PPO300/Complete, & GRID & GRID+**	**PPO200/Complete, PPO300/Complete, & GRID+**	**PPO300/Complete, & GRID+**	**SPECIALIST, & GRID & GRID+**
	100	In Network Pays at and Collect up to 100/Prime/Complete Allowed Amount	In Network Pays at 100/Prime/Complete, Collect up to 200/Complete Allowed Amount	In Network Pays at 100/Prime/Complete, Collect up to 300/Complete Allowed Amount	In- Network Pays at and Collect up to Specialist Allowed Amount
	200	In Network Pays at and Collect up to 200/Complete Allowed Amount	In Network Pays at and Collect up to 200/Complete Allowed Amount	In Network Pays at 200/Complete, Collect up to 300/Complete Allowed Amount	In- Network Pays at and Collect up to Specialist Allowed Amount
	300	In Network Pays at and Collect up to 300/Complete Allowed Amount	In Network Pays at and Collect up to 300/Complete Allowed Amount	In Network Pays at and Collect up to 300/Complete Allowed Amount	In- Network Pays at and Collect up to Specialist Allowed Amount
	100/200/300	In Network Pays at and Collect up to 100/Prime/Complete Allowed Amount	In Network Pays at and Collect up to 200/Complete Allowed Amount	In Network Pays at and Collect up to 300/Complete Allowed Amount	In- Network Pays at and Collect up to Specialist Allowed Amount
	Dental Prime	In Network Pays at and Collect up to 100/Prime/Complete Allowed Amount	OUT OF NETWORK Balance Billing up to providers usual fee	OUT OF NETWORK Balance Billing up to providers usual fee	In- Network Pays at and Collect up to Specialist Allowed Amount
	Dental Complete	In Network Pays at and Collect up to 100/Prime/Complete Allowed Amount	In Network Pays at and Collect up to 200/Complete Allowed Amount	In Network Pays at and Collect up to 300/Complete Allowed Amount	In- Network Pays at and Collect up to Specialist Allowed Amount

Maine Provider Networks

All dentists who have signed a Participation Agreement for Anthem's PPO 100/200/300/Prime/Complete, Discount Program, Anthem Dental PPO and Federal Employee Program networks are considered participating dentists to provide in network benefits to members.

Dental plan payments are made directly to a participating dentist. Payments are subject to the limitations, exclusions, deductibles, co-payments, and annual maximums of the member's dental benefit plan.

Anthem evaluates the allowances, under the member's dental plan, which may be made toward such treatment in accordance with covered benefits under the group contract, and the standards of generally accepted dental practices. Anthem does not interfere with the dentist's diagnosis or treatment plan.

The following pages include descriptions of the Anthem networks and the products they serve. Because there are different networks and coverage plans, it is extremely important that you ask a member for their identification card. Identification cards are not a guarantee of benefits or eligibility but will give you necessary information such as the type of plan, phone number to call for benefits and questions, as well as where to submit claims. Be sure to copy the front and the back of the member's identification card for future reference.

Traditional Provider Network

Anthem Dental PPO

The Anthem Dental PPO network is an established network that has been in service for years. This network is also referred to as our Traditional PPO network.

Any dentist who participates in the PPO network is also participating in the FEP network.

Federal Employee Program (FEP)

The FEP network covers active and retired Federal Employees and their families.

The FEP network contains:

- Basic Option
- Standard Option

Dentists that participate in FEP accept both Basic and Standard Option.

PPO 100/200/300/Prime/Complete

The PPO 100/200/300/Prime/Complete network is Anthem's newest network and is currently being marketed to commercial groups, ASO or fully insured employer groups and individuals.

General dentists may choose between three (3) levels of participation. Dentists choosing to participate in the 100/Prime/Complete level are also agreeing to participate in the 200/Prime/Complete and 300/Complete levels. Dentists choosing to participate in the 200/Prime/Complete level are also agreeing to participate in the 300/Complete level. Dentists choosing to participate in the 300/Complete level are only participating in the 300/Complete level.

Reimbursement is typically a combination of the plan payment and member payment that will equal up to the dentist's contracted allowed amount.

A specialist who participates in the Specialist network is considered participating in all three (3) levels and reimbursement is based on the specialist fee schedule.

Discount Program

The PPO 100/200/300/Prime/Complete Participating Dentist Agreement includes an addendum for those dentists that are interested in participating in the Discount Card Program. In order for a dentist to be eligible to participate in the Discount Card Program they must participate in the 200/Prime/Complete level and accept the 200/Prime/Complete fee schedule. The dentist must actively sign to participate in the Discount Card Program as the program has its own conditions for participation. It is typical for Discount Plans not to have any claims submitted to the plan for reimbursement as the payment for services rendered is received directly from the member at the dentist's contracted 200/Prime/Complete allowed amount at time of service. The dentist is responsible for requesting Discount Program identification material prior to providing services.

Dental Plans, Products or Dental Network Programs Using the PPO100, PPO200, PPO300 Networks

- **Dental Prime** = In-Network if participating in Maine's PPO 100/Prime/Complete AND/OR PPO 200/Prime/Complete
- **Dental Complete** = In-Network if participating in Maine's PPO 100/Prime/Complete AND/OR PPO 200/Prime/Complete AND/OR PPO 300/Complete ONLY
- Dental GRID = In-Network if participating in Maine's PPO 100/Prime/Complete AND/OR PPO 200/Prime/Complete (Prime) as noted above
- **Dental GRID+** = In-Network if participating in Maine's PPO 100/Prime/Complete AND/OR PPO 200/Prime/Complete AND/OR PPO 300/Complete ONLY (Complete) as noted above
- **Dental Blue (DB) PPO100, PPO200, PPO300** = In-Network if participating in PPO 100/Prime/Complete AND/OR PPO 200/Prime/Complete AND/OR PPO 300/Complete ONLY

Note: Dental Plans/Products can have numerous designs as an employer can select what benefits they want to cover for their employees and at different percentage co-insurance levels (i.e. 100/80/50 – classic design)

GRID and GRID+

The national Dental GRID, administered by the GRID Dental Corporation, is one of the country's leading national dental networks.

The national Dental GRID offers customers and members of participating Blue Cross and Blue Shield plans a hassle-free opportunity to access more network dentists and discounts across the country.

This affiliation allows participating dentists to see members who were previously considered "out" of network as "in" network, with the plan payments going directly to the office rather than the member.

The national Dental GRID has two networks: GRID and GRID+.

GRID

- Access is available to Anthem Dental Prime members and members of other participating Blue Cross and Blue Shield Plans.
- Provider reimbursement is equivalent to Prime (PPO 100/Prime/Complete and PPO 200/Prime/Complete).
- Claims are processed "in" network when member is seen by a PPO 100/Prime/Complete or PPO 200/Prime/Complete dentist.
- Claims are processed "out" of network when member is seen by a PPO 300/Complete dentist.
    - PPO 300/Complete dentist may balance bill the member up to their submitted fees.
- Specialists are in network for members who access GRID.

GRID+

- Access is available to Anthem Dental Complete members and members of other participating Blue Cross and Blue Shield Plans.
- Provider reimbursement is equivalent to Complete (PPO 100/Prime/Complete, PPO 200/Prime/Complete, and PPO 300/Complete).
- Member may be seen by any dentist who participates in PPO 100/Prime/Complete, PPO 200/Prime/Complete or PPO 300/Complete.
- Claims are processed at your contracted fee.

- Specialists are in network for members who access GRID+.

Identifying a Member Who Can Access the GRID or GRID+ Network

- A participating plan will issue their own member ID cards indicating the plan name on the front of the card.
- A member's ID card will have either GRID **or** GRID+ on the **back** of their card.
- The Customer Service phone number of the participating plan and the Claims address of where to submit claims for these members will be on the back of the member's ID Card.

Member's coverage:

A participating plan's members receive in network benefits when being seen by dental providers outside of their local plan's service area when the plan participates in the GRID and the network level.

Claims Submission:

Claims are submitted to the plan's claims address, as listed on the back of the member's ID card.

Claims Payments:

Payments are made from the member's plan, directly to the treating dentist. The fee schedule used will be based on the treating doctor's location and participation in the PPO 100/200/300/Prime/Complete networks.

The GRID Dental Corporation is a separate company that provides dental network services on behalf of Anthem Blue Cross and Blue Shield, an independent licensee of the Blue Cross and Blue Shield Association.

PPO 100/200/300/Prime/Complete Plans/Products

The chart below compares reimbursement for the provider networks (PPO 100/200/300/Prime/Complete and GRID/GRID+) that our members may access.

Provider Participation Network Level					
Member / Group / Product		**PPO100/Prime/Complete, PPO200/Prime/Complete, PPO300/Complete, & GRID & GRID+**	**PPO200/Prime/Complete, PPO300/Complete, & GRID & GRID+**	**PPO300/Complete, & GRID+**	**SPECIALIST, & GRID & GRID+**
	100	In Network Pays at and Collect up to 100/Prime/Complete Allowed Amount	In Network Pays at 100/Prime/Complete, Collect up to 200/Prime/Complete Allowed Amount	In Network Pays at 100/Prime/Complete, Collect up to 300/Complete Allowed Amount	In- Network Pays at and Collect up to Specialist Allowed Amount
	200	In Network Pays at and Collect up to 200/Prime/Complete Allowed Amount	In Network Pays at and Collect up to 200/Prime/Complete Allowed Amount	In Network Pays at 200/Prime/Complete, Collect up to 300/Complete Allowed Amount	In- Network Pays at and Collect up to Specialist Allowed Amount
	300	In Network Pays at and Collect up to 300/Complete Allowed Amount	In Network Pays at and Collect up to 300/Complete Allowed Amount	In Network Pays at and Collect up to 300/Complete Allowed Amount	In- Network Pays at and Collect up to Specialist Allowed Amount
	100/200/300	In Network Pays at and Collect up to 100/Prime/Complete Allowed Amount	In Network Pays at and Collect up to 200/Prime/Complete Allowed Amount	In Network Pays at and Collect up to 300/Complete Allowed Amount	In- Network Pays at and Collect up to Specialist Allowed Amount
	Dental Prime	In Network Pays at and Collect up to 100/Prime/Complete Allowed Amount	In Network Pays at and Collect up to 200/Prime/Complete Allowed Amount	OUT OF NETWORK Balance Billing up to providers usual fee	In- Network Pays at and Collect up to Specialist Allowed Amount
	Dental Complete	In Network Pays at and Collect up to 100/Prime/Complete Allowed Amount	In Network Pays at and Collect up to 200/Prime/Complete Allowed Amount	In Network Pays at and Collect up to 300/Complete Allowed Amount	In- Network Pays at and Collect up to Specialist Allowed Amount

Missouri Provider Networks

All dentists who have signed a Participation Agreement for Anthem's PPO 100/200/300/Prime/Complete, Discount Program, Anthem PPO, and Federal Employee Program networks are considered participating dentists to provide in network benefits to members.

Dental plan payments are made directly to a participating dentist. Payments are subject to the limitations, exclusions, deductibles, co-payments, and annual maximums of the member's dental benefit plan.

Anthem evaluates the allowances, under the member's dental plan, which may be made toward such treatment in accordance with covered benefits under the group contract, and the standards of generally accepted dental practices. Anthem does not interfere with the dentist's diagnosis or treatment plan.

The following pages include descriptions of the Anthem networks and the products they serve. Because there are different networks and coverage plans, it is extremely important that you ask a member for their identification card. Identification cards are not a guarantee of benefits or eligibility but will give you necessary information such as the type of plan, phone number to call for benefits and questions, as well as where to submit claims. Be sure to copy the front and the back of the member's identification card for future reference.

Traditional Provider Network

Anthem Dental PPO

The Anthem Dental PPO network is an established network that has been in service for years. This network is also referred to as our Traditional PPO network.

Any dentist who participates in the PPO network has the option to also participate in the FEP network.

Federal Employee Program (FEP)

The FEP network covers active and retired Federal Employees and their families.

The FEP network contains:

- Basic Option
- Standard Option

Dentists that participate in FEP accept both Basic and Standard Option.

PPO 100/200/300/Prime/Complete

The PPO 100/200/300/Prime/Complete network is Anthem's newest network and is currently being marketed to commercial groups, ASO or fully insured employer groups and individuals.

General dentists may choose between three (3) levels of participation. Dentists choosing to participate in the 100/Prime Complete level are also agreeing to participate in the 200/Prime/Complete and 300/Complete levels. Dentists choosing to participate in the 200/Prime/Complete level are also agreeing to participate in the 300/Complete level. Dentists choosing to participate in the 300/Complete level are only participating in the 300/Complete level.

Reimbursement is typically a combination of the plan payment and member payment that will equal up to the dentist's contracted allowed amount.

A specialist who participates in the Specialist network is considered participating in all three (3) levels and reimbursement is based on the specialist fee schedule.

Discount Program

The PPO 100/200/300/Prime/Complete Participating Dentist Agreement includes an addendum for those dentists that are interested in participating in the Discount Card Program. In order for a dentist to be eligible to participate in the Discount Card Program they must participate in the 200/Prime/Complete level and accept the 200/Prime/Complete fee schedule. The dentist must actively sign to participate in the Discount Card Program as the program has its own conditions for participation. It is typical for Discount Plans not to have any claims submitted to the plan for reimbursement as the payment for services rendered is received directly from the member at the dentist's contracted 200/Prime/Complete allowed amount at time of service. The dentist is responsible for requesting Discount Program identification material prior to providing services.

Dental Plans, Products or Dental Network Programs Using the PPO 100/200/300/Prime/Complete Network

- **Dental Prime** = In-Network if participating in Missouri's PPO 100/Prime/Complete AND/OR PPO 200/Prime/Complete
- **Dental Complete** = In-Network if participating in Missouri's PPO 100/Prime/Complete AND/OR PPO 200/Prime/Complete AND/OR PPO 300/Complete ONLY

- **Dental GRID** = In-Network if participating in Missouri's PPO 100/Prime/Complete AND/OR PPO 200/Prime/Complete (Prime) as noted above
- **Dental GRID+** = In-Network if participating in Missouri's PPO 100/Prime/Complete AND/OR PPO 200/Prime/Complete AND/OR PPO 300/Complete ONLY (Complete) as noted above
- **Dental Blue (DB) PPO100, PPO200, PPO300** = In-Network if participating in Missouri's PPO 100/Prime/Complete AND/OR PPO 200/Prime/Complete AND/OR PPO 300/Complete ONLY

Note: Dental Plans/Products can have numerous designs as an employer can select what benefits they want to cover for their employees and at different percentage co-insurance levels (i.e. 100/80/50 – classic design).

GRID and GRID+

The national Dental GRID, administered by the GRID Dental Corporation, is one of the country's leading national dental networks.

The national Dental GRID offers customers and members of participating Blue Cross and Blue Shield plans a hassle-free opportunity to access more network dentists and discounts across the country.

This affiliation allows participating dentists to see members who were previously considered "out" of network as "in" network, with the plan payments going directly to the office rather than the member.

The national Dental GRID has two networks: GRID and GRID+.

GRID

- Access is available to Anthem Dental Prime members and members of other participating Blue Cross and Blue Shield Plans.
- Provider reimbursement is equivalent to Prime (PPO 100/Prime/Complete or PPO 200/Prime/Complete).
- Claims are processed "in" network when member is seen by a PPO 100/Prime/Complete or PPO 200/Prime/Complete dentist.
- Claims are processed "out" of network when member is seen by a PPO 300/Complete dentist.
    - PPO 300/Complete dentists may balance bill the member up to their submitted fees.
- Specialists are in network for members who access GRID.

GRID+

- Access is available to Anthem Dental Complete members and members of other participating Blue Cross and Blue Shield Plans.
- Provider reimbursement is equivalent to Complete (PPO 100/Prime/Complete, PPO 200/Prime/Complete, and PPO 300/Complete).
- Member may be seen by any dentist who participates in PPO 100/Prime/Complete, PPO 200/Prime/Complete or PPO 300/Complete.
- Claims are processed at your contracted fee.
- Specialists are in network for members who access GRID+.

Identifying a Member Who Can Access the GRID or GRID+ Network

- A participating plan will issue their own member ID cards indicating the plan name on the front of the card.

- A member's ID card will have either GRID **or** GRID+ on the **back** of their card.
- The Customer Service phone number of the participating plan and the Claims address of where to submit claims for these members will be on the back of the member's ID Card.

Member'scoverage:

A participating plan's members receive in network benefits when being seen by dental providers outside of their local plan's service area when the plan participates in the GRID and the network level.

Claims Submission:

Claims are submitted to the plan's claims address, as listed on the back of the member's ID card.

Claims Payments:

Payments are made from the member's plan, directly to the treating dentist. The fee schedule used will be based on the treating doctor's location and participation in the PPO 100/200/300/Prime/Complete networks.

The GRID Dental Corporation is a separate company that provides dental network services on behalf of Anthem Blue Cross and Blue Shield, an independent licensee of the Blue Cross and Blue Shield Association.

PPO 100/200/300/Prime/Complete Plans/Products

The chart below compares reimbursement for the provider networks (PPO 100/200/300/Prime/Complete and GRID/GRID+) that our members may access.

Provider Participation Network Level					
Member / Group / Product		**PPO100/Prime/Complete, PPO200/Prime/Complete, PPO300/Complete, & GRID & GRID+**	**PPO200/Prime/Complete, PPO300/Complete, & GRID & GRID+**	**PPO300/Complete, & GRID+**	**SPECIALIST, & GRID & GRID+**
	100	In Network Pays at and Collect up to 100/Prime/Complete Allowed Amount	In Network Pays at 100/Prime/Complete, Collect up to 200/Prime/Complete Allowed Amount	In Network Pays at 100/Prime/Complete, Collect up to 300/Complete Allowed Amount	In- Network Pays at and Collect up to Specialist Allowed Amount
	200	In Network Pays at and Collect up to 200/Prime/Complete Allowed Amount	In Network Pays at and Collect up to 200/Prime/Complete Allowed Amount	In Network Pays at 200/Prime/Complete, Collect up to 300/Complete Allowed Amount	In- Network Pays at and Collect up to Specialist Allowed Amount
	300	In Network Pays at and Collect up to 300/Complete Allowed Amount	In Network Pays at and Collect up to 300/Complete Allowed Amount	In Network Pays at and Collect up to 300/Complete Allowed Amount	In- Network Pays at and Collect up to Specialist Allowed Amount
	100/200/300	In Network Pays at and Collect up to 100/Prime/Complete Allowed Amount	In Network Pays at and Collect up to 200/Prime/Complete Allowed Amount	In Network Pays at and Collect up to 300/Complete Allowed Amount	In- Network Pays at and Collect up to Specialist Allowed Amount
	Dental Prime	In Network Pays at and Collect up to 100/Prime/Complete Allowed Amount	In Network Pays at and Collect up to 200/Prime/Complete Allowed Amount	OUT OF NETWORK Balance Billing up to providers usual fee	In- Network Pays at and Collect up to Specialist Allowed Amount
	Dental Complete	In Network Pays at and Collect up to 100/Prime/Complete Allowed Amount	In Network Pays at and Collect up to 200/Prime/Complete Allowed Amount	In Network Pays at and Collect up to 300/Complete Allowed Amount	In- Network Pays at and Collect up to Specialist Allowed Amount

New Hampshire Provider Networks

All dentists who have signed a Participation Agreement for Anthem's PPO 100/200/300/Prime/Complete, Discount Program, Anthem Dental PPO and Federal Employee Program networks are considered participating dentists to provide in network benefits to members.

Dental plan payments are made directly to a participating dentist. Payments are subject to the limitations, exclusions, deductibles, co-payments, and annual maximums of the member's dental benefit plan.

Anthem evaluates the allowances, under the member's dental plan, which may be made toward such treatment in accordance with covered benefits under the group contract, and the standards of generally accepted dental practices. Anthem does not interfere with the dentist's diagnosis or treatment plan.

The following pages include descriptions of the Anthem networks and the products they serve. Because there are different networks and coverage plans, it is extremely important that you ask a member for their identification card. Identification cards are not a guarantee of benefits or eligibility but will give you necessary information such as the type of plan, phone number to call for benefits and questions, as well as where to submit claims. Be sure to copy the front and the back of the member's identification card for future reference.

Traditional Provider Network

Anthem Dental PPO

The Anthem Dental PPO network is an established network that has been in service for years. This network is also referred to as out Traditional PPO network.

Federal Employee Program (FEP)

The FEP network covers active and retired Federal Employees and their families.

The FEP network contains:

- Basic Option
- Standard Option

Dentists who participate in FEP accept both Basic and Standard Option.

PPO 100/200/300/Prime/Complete

The PPO 100/200/300/Prime/Complete network is Anthem's newest network and is currently being marketed to commercial groups, ASO or fully insured employer groups and individuals.

General dentists may choose between three (3) levels of participation. Dentists choosing to participate in the 100/Prime/Complete level are also agreeing to participate in the 200/Complete and 300/Complete levels. Dentists choosing to participate in the 200/Complete level are also agreeing to participate in the 300/Complete level. Dentists choosing to participate in the 300/Complete level are only participating in the 300/Complete level.

Reimbursement is typically a combination of the plan payment and member payment that will equal up to the dentist's contracted allowed amount.

A specialist who participates in the Specialist network is considered participating in all three (3) levels and reimbursement is based on the specialist fee schedule.

Discount Program

The PPO 100/200/300/Prime/Complete Participating Dentist Agreement includes an addendum for those dentists that are interested in participating in the Discount Card Program. In order for a dentist to be eligible to participate in the Discount Card Program they must participate in the 200/Complete level and accept the 200/Complete fee schedule. The dentist must actively sign to participate in the Discount Card Program as the program has its own conditions for participation. It is typical for Discount Plans not to have any claims submitted to the plan for reimbursement as the payment for services rendered is received directly from the member at the dentist's contracted 200/Complete allowed amount at time of service. The dentist is responsible for requesting Discount Program identification material prior to providing services.

Dental Plans, Products or Dental Network Programs Using the PPO 100/200/300/Prime/Complete Networks

- **Dental Prime** = In-Network if participating in New Hampshire's PPO 100/Prime/Complete
- **Dental Complete** = In-Network if participating in New Hampshire's PPO 100/Prime/Complete AND/OR PPO 200/Complete AND/OR PPO 300/Complete ONLY

- **Dental GRID** = In-Network if participating in New Hampshire's PPO 100/Prime/Complete (Prime) as noted above
- **Dental GRID+** = In-Network if participating in New Hampshire's PPO 100/Prime/Complete AND/OR PPO 200/Complete AND/OR PPO 300/Complete ONLY (Complete) as noted above
- **Dental Blue (DB) PPO100, PPO200, PPO300** = In-Network if participating in New Hampshire's PPO 100/Prime/Complete AND/OR PPO 200/Complete AND/OR PPO 300/Complete ONLY

Note: Dental Plans/Products can have numerous designs as an employer can select what benefits they want to cover for their employees and at different percentage co-insurance levels (i.e. 100/80/50 – classic design)

GRID and GRID+

The national Dental GRID, administered by the GRID Dental Corporation, is one of the country's leading national dental networks.

The national Dental GRID offers customers and members of participating Blue Cross and Blue Shield plans a hassle-free opportunity to access more network dentists and discounts across the country.

This affiliation allows participating dentists to see members who were previously considered "out" of network as "in" network, with the plan payments going directly to the office rather than the member.

The national Dental GRID has two networks: GRID and GRID+.

GRID

- Access is available to Anthem Dental Prime members and members of other participating Blue Cross and Blue Shield Plans.
- Provider reimbursement is equivalent to Prime (PPO 100/Prime/Complete).
- Claims are processed "in" network when member is seen by a PPO 100/Prime/Complete dentist.
- Claims are processed "out" of network when member is seen by a PPO 200/Complete or PPO 300/Complete dentist.
    - PPO 200/Complete or PPO 300/Complete dentist may balance bill the member up to their submitted fees.
- Specialists are in network for members who access GRID.

GRID+

- Access is available to Anthem Dental Complete members and members of other participating Blue Cross and Blue Shield Plans.
- Provider reimbursement is equivalent to Complete (PPO 100/Prime/Complete, PPO 200/Complete, and PPO 300/Complete).
- Member may be seen by any dentist who participates in PPO 100/Prime/Complete, PPO 200/Complete or PPO 300/Complete.
- Claims are processed at your contracted fee.
- Specialists are in network for members who access GRID+.

Identifying a Member Who Can Access the GRID or GRID+ Network

- A participating plan will issue their own member ID cards indicating the plan name on the front of the card.
- A member's ID card will have either GRID **or** GRID+ on the **back** of their card.
- The Customer Service phone number of the participating plan and the Claims address of where to submit claims for these members will be on the back of the member's ID Card.

Member's coverage:

A participating plan's members receive in network benefits when being seen by dental providers outside of their local plan's service area when the plan participates in the GRID and the network level.

Claims Submission:

Claims are submitted to the plan's claims address, as listed on the back of the member's ID card.

Claims Payments:

Payments are made from the member's plan, directly to the treating dentist. The fee schedule used will be based on the treating doctor's location and participation in the PPO 100/200/300/Prime/Complete networks.

The GRID Dental Corporation is a separate company that provides dental network services on behalf of Anthem Blue Cross and Blue Shield, an independent licensee of the Blue Cross and Blue Shield Association.

PPO 100/200/300/Prime/Complete Plans/Products

The chart below compares reimbursement for the provider networks (PPO 100/200/300/Prime/Complete and GRID/GRID+) that our members may access.

Provider Participation Network Level					
Member / Group / Product		**PPO100/Prime/Complete, PPO200/Complete, PPO300/Complete, & GRID & GRID+**	**PPO200/Complete, PPO300/Complete, & GRID+**	**PPO300/Complete, & GRID+**	**SPECIALIST, & GRID & GRID+**
	100	In Network Pays at and Collect up to 100/Prime/Complete Allowed Amount	In Network Pays at 100/Prime/Complete, Collect up to 200/Complete Allowed Amount	In Network Pays at 100/Prime/Complete, Collect up to 300/Complete Allowed Amount	In- Network Pays at and Collect up to Specialist Allowed Amount
	200	In Network Pays at and Collect up to 200/Complete Allowed Amount	In Network Pays at and Collect up to 200/Complete Allowed Amount	In Network Pays at 200/Complete, Collect up to 300/Complete Allowed Amount	In- Network Pays at and Collect up to Specialist Allowed Amount
	300	In Network Pays at and Collect up to 300/Complete Allowed Amount	In Network Pays at and Collect up to 300/Complete Allowed Amount	In Network Pays at and Collect up to 300/Complete Allowed Amount	In- Network Pays at and Collect up to Specialist Allowed Amount
	100/200/300	In Network Pays at and Collect up to 100/Prime/Complete Allowed Amount	In Network Pays at and Collect up to 200/Complete Allowed Amount	In Network Pays at and Collect up to 300/Complete Allowed Amount	In- Network Pays at and Collect up to Specialist Allowed Amount
	Dental Prime	In Network Pays at and Collect up to 100/Prime/Complete Allowed Amount	OUT OF NETWORK Balance Billing up to providers usual fee	OUT OF NETWORK Balance Billing up to providers usual fee	In- Network Pays at and Collect up to Specialist Allowed Amount
	Dental Complete	In Network Pays at and Collect up to 100/Prime/Complete Allowed Amount	In Network Pays at and Collect up to 200/Complete Allowed Amount	In Network Pays at and Collect up to 300/Complete Allowed Amount	In- Network Pays at and Collect up to Specialist Allowed Amount

Nevada Provider Networks

All dentists who have signed a Participation Agreement for Anthem's PPO 100/200/300/Prime/Complete, Discount Program, Anthem Blue Dental PPO, PPO Plus and Federal Employee Program networks are considered participating dentists to provide in network benefits to members.

Dental plan payments are made directly to a participating dentist. Payments are subject to the limitations, exclusions, deductibles, co-payments, and annual maximums of the member's dental benefit plan.

Anthem evaluates the allowances, under the member's dental plan, which may be made toward such treatment in accordance with covered benefits under the group contract, and the standards of generally accepted dental practices. Anthem does not interfere with the dentist's diagnosis or treatment plan.

The following pages include descriptions of the Anthem networks and the products they serve. Because there are different networks and coverage plans, it is extremely important that you ask a member for their identification card. Identification cards are not a guarantee of benefits or eligibility but will give you necessary information such as the type of plan, phone number to call for benefits and questions, as well as where to submit claims. Be sure to copy the front and the back of the member's identification card for future reference.

Traditional Provider Network

Anthem Blue Dental PPO and PPO Plus

The Anthem Blue Dental PPO and PPO Plus networks are established networks that have been in service for years. These networks are also referred to as our PPO and PPO Plus networks.

Any dentist who participates in the PPO and PPO Plus networks is also participating in the FEP network.

Federal Employee Program (FEP)

The FEP network covers active and retired Federal Employees and their families.

The FEP network contains:

- Basic Option
- Standard Option

Dentists that participate in FEP accept both Basic and Standard Option.

PPO 100/200/300/Prime/Complete

The PPO 100/200/300/Prime/Complete network is Anthem's newest network and is currently being marketed to commercial groups, ASO or fully insured employer groups and individuals.

General dentists may choose between three (3) levels of participation. Dentists choosing to participate in the 100/Prime/Complete level are also agreeing to participate in the 200/Complete and 300/Complete levels. Dentists choosing to participate in the 200/Complete level are also agreeing to participate in the 300/Complete level. Dentists choosing to participate in the 300/Complete level are only participating in the 300 level.

Reimbursement is typically a combination of the plan payment and member payment that will equal up to the dentist's contracted allowed amount.

A specialist who participates in the Specialist network is considered participating in all three (3) levels and reimbursement is based on the specialist fee schedule.

Discount Program

The PPO 100/200/300/Prime/Complete Participating Dentist Agreement includes an addendum for those dentists that are interested in participating in the Discount Card Program. In order for a dentist to be eligible to participate in the Discount Card Program they must participate in the 200/Complete level and accept the 200/Complete fee schedule. The dentist must actively sign to participate in the Discount Card Program as the program has its own conditions for participation. It is typical for Discount Plans not to have any claims submitted to the plan for reimbursement as the payment for services rendered is received directly from the member at the dentist's contracted 200/Complete allowed amount at time of service. The dentist is responsible for requesting Discount Program identification material prior to providing services.

Dental Plans, Products or Dental Network Programs Using the PPO 100/200/300/Prime/Complete Networks

- **Dental Prime** = In-Network if participating in Nevada's PPO 100/Prime/Complete
- **Dental Complete** = In-Network if participating in Nevada's PPO 100/Prime/Complete AND/OR PPO 200/Complete AND/OR PPO 300/Complete ONLY

- **Dental GRID** = In-Network if participating in Nevada's PPO 100/Prime/Complete (Prime) as noted above
- **Dental GRID+** = In-Network if participating in Nevada's PPO 100/Prime/Complete AND/OR PPO 200/Complete AND/OR PPO 300/Complete ONLY (Complete) as noted above
- **Dental Blue (DB) PPO100, PPO200, PPO300** = In-Network if participating in Nevada's PPO 100/Prime/Complete AND/OR PPO 200/Complete AND/OR PPO 300/Complete ONLY

Note: Dental Plans/Products can have numerous designs as an employer can select what benefits they want to cover for their employees and at different percentage co-insurance levels (i.e. 100/80/50 – classic design)

GRID and GRID+

The national Dental GRID, administered by the GRID Dental Corporation, is one of the country's leading national dental networks.

The national Dental GRID offers customers and members of participating Blue Cross and Blue Shield plans a hassle-free opportunity to access more network dentists and discounts across the country.

This affiliation allows participating dentists to see members who were previously considered "out" of network as "in" network, with the plan payments going directly to the office rather than the member.

The national Dental GRID has two networks: GRID and GRID+.

GRID

- Access is available to Anthem Dental Prime members and members of other participating Blue Cross and Blue Shield Plans.
- Provider reimbursement is equivalent to Prime (PPO 100/Prime/Complete).
- Claims are processed "in" network when member is seen by a PPO 100/Prime/Complete dentist.
- Claims are processed "out" of network when member is seen by a PPO 200/Complete or PPO 300/Complete dentist.
    - PPO 200/Complete or PPO 300/Complete dentist may balance bill the member up to their submitted fees.
- Specialists are in network for members who access GRID.

GRID+

- Access is available to Anthem Dental Complete members and members of other participating Blue Cross and Blue Shield Plans.
- Provider reimbursement is equivalent to Complete (PPO 100/Prime/Complete, PPO 200/Complete, and PPO 300/Complete).
- Member may be seen by any dentist who participates in PPO 100/Prime/Complete, PPO 200/Complete or PPO 300/Complete.
- Claims are processed at your contracted fee.
- Specialists are in network for members who access GRID+.

Identifying a Member Who Can Access the GRID or GRID+ Network

- A participating plan will issue their own member ID cards indicating the plan name on the front of the card.
- A member's ID card will have either GRID **or** GRID+ on the **back** of their card.
- The Customer Service phone number of the participating plan and the Claims address of where to submit claims for these members will be on the back of the member's ID Card.

Member's coverage:

A participating plan's members receive in network benefits when being seen by dental providers outside of their local plan's service area when the plan participates in the GRID and the network level.

Claims Submission:

Claims are submitted to the plan's claims address, as listed on the back of the member's ID card.

Claims Payments:

Payments are made from the member's plan, directly to the treating dentist. The fee schedule used will be based on the treating doctor's location and participation in the PPO 100/200/300/Prime/Complete networks.

The GRID Dental Corporation is a separate company that provides dental network services on behalf of Anthem Blue Cross and Blue Shield, an independent licensee of the Blue Cross and Blue Shield Association.

PPO 100/200/300/Prime/Complete Plans/Products

The chart below compares reimbursement for the provider networks (PPO 100/200/300/Prime/Complete and GRID/GRID+) that our members may access.

Provider Participation Network Level					
Member / Group / Product		**PPO100/Prime/Complete, PPO200/Complete, PPO300/Complete, & GRID & GRID+**	**PPO200/Complete, PPO300/Complete, & GRID+**	**PPO300/Complete, & GRID+**	**SPECIALIST, & GRID & GRID+**
	100	In Network Pays at and Collect up to 100/Prime/Complete Allowed Amount	In Network Pays at 100/Prime/Complete, Collect up to 200/Complete Allowed Amount	In Network Pays at 100/Prime/Complete, Collect up to 300/Complete Allowed Amount	In- Network Pays at and Collect up to Specialist Allowed Amount
	200	In Network Pays at and Collect up to 200/Complete Allowed Amount	In Network Pays at and Collect up to 200/Complete Allowed Amount	In Network Pays at 200/Complete, Collect up to 300/Complete Allowed Amount	In- Network Pays at and Collect up to Specialist Allowed Amount
	300	In Network Pays at and Collect up to 300/Complete Allowed Amount	In Network Pays at and Collect up to 300/Complete Allowed Amount	In Network Pays at and Collect up to 300/Complete Allowed Amount	In- Network Pays at and Collect up to Specialist Allowed Amount
	100/200/300	In Network Pays at and Collect up to 100/Prime/Complete Allowed Amount	In Network Pays at and Collect up to 200/Complete Allowed Amount	In Network Pays at and Collect up to 300/Complete Allowed Amount	In- Network Pays at and Collect up to Specialist Allowed Amount
	Dental Prime	In Network Pays at and Collect up to 100/Prime/Complete Allowed Amount	OUT OF NETWORK Balance Billing up to providers usual fee	OUT OF NETWORK Balance Billing up to providers usual fee	In- Network Pays at and Collect up to Specialist Allowed Amount
	Dental Complete	In Network Pays at and Collect up to 100/Prime/Complete Allowed Amount	In Network Pays at and Collect up to 200/Complete Allowed Amount	In Network Pays at and Collect up to 300/Complete Allowed Amount	In- Network Pays at and Collect up to Specialist Allowed Amount

Ohio Provider Networks

All dentists who have signed a Participation Agreement for Anthem's PPO 100/200/300/Prime/Complete, Discount Program, Anthem Dental PPO, and Federal Employee Program networks are considered participating dentists to provide in network benefits to members.

Dental plan payments are made directly to a participating dentist. Payments are subject to the limitations, exclusions, deductibles, co-payments, and annual maximums of the member's dental benefit plan.

Anthem evaluates the allowances, under the member's dental plan, which may be made toward such treatment in accordance with covered benefits under the group contract, and the standards of generally accepted dental practices. Anthem does not interfere with the dentist's diagnosis or treatment plan.

The following pages include descriptions of the Anthem networks and the products they serve. Because there are different networks and coverage plans, it is extremely important that you ask a member for their identification card. Identification cards are not a guarantee of benefits or eligibility but will give you necessary information such as the type of plan, phone number to call for benefits and questions, as well as where to submit claims. Be sure to copy the front and the back of the member's identification card for future reference.

Traditional Provider Network

Anthem Dental PPO

The Anthem Dental PPO network is an established network that has been in service for years. This network is also referred to as our Traditional PPO network.

Any dentist who participates in the PPO network is also participating in the FEP network.

Federal Employee Program (FEP)

The FEP network covers active and retired Federal Employees and their families.

The FEP network contains:

- Basic Option
- Standard Option

Dentists that participate in FEP accept both Basic and Standard Option.

PPO 100/200/300/Prime/Complete

The PPO 100/200/300/Prime/Complete network is Anthem's newest network and is currently being marketed to commercial groups, ASO or fully insured employer groups and individuals.

General dentists may choose between three (3) levels of participation. Dentists choosing to participate in the 100/Prime/Complete level are also agreeing to participate in the 200/Prime/Complete and 300/Complete levels. Dentists choosing to participate in the 200/Prime/Complete level are also agreeing to participate in the 300/Complete level. Dentists choosing to participate in the 300/Complete level are only participating in the 300/Complete level.

Reimbursement is typically a combination of the plan payment and member payment that will equal up to the dentist's contracted allowed amount.

A specialist who participates in the Specialist network is considered participating in all three (3) levels and reimbursement is based on the specialist fee schedule.

Discount Program

The PPO 100/200/300/Prime/Complete Participating Dentist Agreement includes an addendum for those dentists that are interested in participating in the Discount Card Program. In order for a dentist to be eligible to participate in the Discount Card Program they must participate in the 200/Prime/Complete level and accept the 200/Prime/Complete fee schedule. The dentist must actively sign to participate in the Discount Card Program as the program has its own conditions for participation. It is typical for Discount Plans not to have any claims submitted to the plan for reimbursement as the payment for services rendered is received directly from the member at the dentist's contracted 200/Prime/Complete allowed amount at time of service. The dentist is responsible for requesting Discount Program identification material prior to providing services.

Dental Plans, Products or Dental Network Programs Using the PPO 100/200/300/Prime/Complete Networks

- **Dental Prime** = In-Network if participating in Ohio's PPO 100/Prime/Complete AND/OR PPO 200/Prime/Complete

- **Dental Complete** = In-Network if participating in Ohio's PPO 100/Prime/Complete AND/OR PPO 200/Prime/Complete AND/OR PPO 300/Complete ONLY
- **Dental GRID** = In-Network if participating in Ohio's PPO 100/Prime/Complete AND/OR PPO 200/Prime/Complete (Prime) as noted above
- **Dental GRID+** = In-Network if participating in Ohio's PPO 100/Prime/Complete AND/OR PPO 200/Prime/Complete AND/OR PPO 300/Complete ONLY (Complete) as noted above
- **Dental Blue (DB) PPO100, PPO200, PPO300** = In-Network if participating in Ohio's PPO 100/Prime/Complete AND/OR PPO 200/Prime/Complete AND/OR PPO 300/Complete ONLY

Note: Dental Plans/Products can have numerous designs as an employer can select what benefits they want to cover for their employees and at different percentage co-insurance levels (i.e. 100/80/50 – classic design)

GRID and GRID+

The national Dental GRID, administered by the GRID Dental Corporation, is one of the country's leading national dental networks.

The national Dental GRID offers customers and members of participating Blue Cross and Blue Shield plans a hassle-free opportunity to access more network dentists and discounts across the country.

This affiliation allows participating dentists to see members who were previously considered "out" of network as "in" network, with the plan payments going directly to the office rather than the member.

The national Dental GRID has two networks: GRID and GRID+.

GRID

- Access is available to Anthem Dental Prime members and members of other participating Blue Cross and Blue Shield Plans.
- Provider reimbursement is equivalent to Prime (PPO 100/Prime/Complete or PPO 200/Prime/Complete).
- Claims are processed "in" network when member is seen by a PPO 100/Prime/Complete or PPO 200/Prime/Complete dentist.
- Claims are processed "out" of network when member is seen by a PPO 300/Complete dentist.
    - PPO 300/Complete dentists may balance bill the member up to their submitted fees.
- Specialists are in network for members who access GRID.

GRID+

- Access is available to Anthem Dental Complete members and members of other participating Blue Cross and Blue Shield Plans.
- Provider reimbursement is equivalent to Complete (PPO 100/Prime/Complete, PPO 200/Prime/Complete, and PPO 300/Complete).
- Member may be seen by any dentist who participates in PPO 100/Prime/Complete, PPO 200/Prime/Complete or PPO 300/Complete.
- Claims are processed at your contracted fee.
- Specialists are in network for members who access GRID+.

Identifying a Member Who Can Access the GRID or GRID+ Network

- A participating plan will issue their own member ID cards indicating the plan name on the front of the card.
- A member's ID card will have either GRID **or** GRID+ on the **back** of their card.
- The Customer Service phone number of the participating plan and the Claims address of where to submit claims for these members will be on the back of the member's ID Card.

Member's coverage:

A participating plan's members receive in network benefits when being seen by dental providers outside of their local plan's service area when the plan participates in the GRID and the network level.

Claims Submission:

Claims are submitted to the plan's claims address, as listed on the back of the member's ID card.

Claims Payments:

Payments are made from the member's plan, directly to the treating dentist. The fee schedule used will be based on the treating doctor's location and participation in the PPO 100/200/300/Prime/Complete networks.

The GRID Dental Corporation is a separate company that provides dental network services on behalf of Anthem Blue Cross and Blue Shield, an independent licensee of the Blue Cross and Blue Shield Association.

PPO 100/200/300/Prime/Complete Plans/Products

The chart below compares reimbursement for the provider networks (PPO 100/200/300/Prime/Complete and GRID/GRID+) that our members may access.

Provider Participation Network Level					
Member / Group / Product		**PPO100/Prime/Complete, PPO200/Prime/Complete, PPO300/Complete, & GRID & GRID+**	**PPO200/Prime/Complete, PPO300/Complete, & GRID & GRID+**	**PPO300/Complete, & GRID+**	**SPECIALIST, & GRID & GRID+**
	100	In Network Pays at and Collect up to 100/Prime/Complete Allowed Amount	In Network Pays at 100/Prime/Complete, Collect up to 200/Prime/Complete Allowed Amount	In Network Pays at 100/Prime/Complete, Collect up to 300/Complete Allowed Amount	In- Network Pays at and Collect up to Specialist Allowed Amount
	200	In Network Pays at and Collect up to 200/Prime/Complete Allowed Amount	In Network Pays at and Collect up to 200/Prime/Complete Allowed Amount	In Network Pays at 200/Prime/Complete, Collect up to 300/Complete Allowed Amount	In- Network Pays at and Collect up to Specialist Allowed Amount
	300	In Network Pays at and Collect up to 300/Complete Allowed Amount	In Network Pays at and Collect up to 300/Complete Allowed Amount	In Network Pays at and Collect up to 300/Complete Allowed Amount	In- Network Pays at and Collect up to Specialist Allowed Amount
	100/200/300	In Network Pays at and Collect up to 100/Prime/Complete Allowed Amount	In Network Pays at and Collect up to 200/Prime/Complete Allowed Amount	In Network Pays at and Collect up to 300/Complete Allowed Amount	In- Network Pays at and Collect up to Specialist Allowed Amount
	Dental Prime	In Network Pays at and Collect up to 100/Prime/Complete Allowed Amount	In Network Pays at and Collect up to 200/Prime/Complete Allowed Amount	OUT OF NETWORK Balance Billing up to providers usual fee	In- Network Pays at and Collect up to Specialist Allowed Amount
	Dental Complete	In Network Pays at and Collect up to 100/Prime/Complete Allowed Amount	In Network Pays at and Collect up to 200/Prime/Complete Allowed Amount	In Network Pays at and Collect up to 300/Complete Allowed Amount	In- Network Pays at and Collect up to Specialist Allowed Amount

Virginia Provider Networks

All dentists who have signed a Participation Agreement for Anthem's PPO 100/200/300/Prime/Complete, Anthem Dental PPO, and Federal Employee Program networks are considered participating dentists to provide in network benefits to members.

Dental plan payments are made directly to a participating dentist. Payments are subject to the limitations, exclusions, deductibles, co-payments, and annual maximums of the member's dental benefit plan.

Anthem evaluates the allowances, under the member's dental plan, which may be made toward such treatment in accordance with covered benefits under the group contract, and the standards of generally accepted dental practices. Anthem does not interfere with the dentist's diagnosis or treatment plan.

The following pages include descriptions of the Anthem networks and the products they serve. Because there are different networks and coverage plans, it is extremely important that you ask a member for their identification card. Identification cards are not a guarantee of benefits or eligibility but will give you necessary information such as the type of plan, phone number to call for benefits and questions, as well as where to submit claims. Be sure to copy the front and the back of the member's identification card for future reference.

Traditional Provider Network

Anthem Dental PPO (PAR PPO/Econ)

The Anthem Dental PPO network is an established network that has been in service for years. This network is also referred to as our Traditional PPO network.

Any dentist who participates in the PPO network is also participating in the FEP network as supported by the Econ Maximum Allowable Amount (Econ MAA).

Federal Employee Program (FEP)

The FEP network covers active and retired Federal Employees and their families.

The FEP network contains:

- Basic Option
- Standard Option

Dentists that participate in FEP accept both Basic and Standard Option.

PPO100/200/300/Prime/Complete

The PPO 100/200/300/Prime/Complete network is Anthem's newest network and is currently being marketed to commercial groups, ASO or fully insured employer groups and individuals.

General dentists may choose between three (3) levels of participation. Dentists choosing to participate in the 100/Prime/Complete level are also agreeing to participate in the 200/Prime/Complete and 300/Complete levels. Dentists choosing to participate in the 200/Prime/Complete level are also agreeing to participate in the 300/Complete level. Dentists choosing to participate in the 300/Complete level are only participating in the 300/Complete level.

Reimbursement is typically a combination of the plan payment and member payment that will equal up to the dentist's contracted allowed amount.

A specialist who participates in the Specialist network is considered participating in all three (3) levels and reimbursement is based on the specialist fee schedule.

Dental Plans, Products or Dental Network Programs Using the PPO 100/200/300/Prime/Complete Networks

- **Dental Prime** = In-Network if participating in Virginia's PPO 100/Prime/Complete AND/OR PPO 200/Prime/Complete
- **Dental Complete** = In-Network if participating in Virginia's PPO 100/Prime/Complete AND/OR PPO 200/Prime/Complete AND/OR PPO 300/Complete ONLY
- **Dental GRID** = In-Network if participating in Virginia's PPO 100/Prime/Complete AND/OR PPO 200/Prime/Complete (Prime) as noted above
- **Dental GRID+** = In-Network if participating in Virginia's PPO 100/Prime/Complete AND/OR PPO 200/Prime/Complete AND/OR PPO 300/Complete ONLY (Complete) as noted above
- **Dental Blue (DB) PPO100, PPO200, PPO300** = In-Network if participating in Virginia's PPO 100/Prime/Complete AND/OR PPO 200/Prime/Complete AND/OR PPO 300/Complete ONLY

Note: Dental Plans/Products can have numerous designs as an employer can select what benefits they want to cover for their employees and at different percentage co-insurance levels (i.e. 100/80/50 – classic design).

GRID and GRID+

The national Dental GRID, administered by the GRID Dental Corporation, is one of the country's leading national dental networks.

The national Dental GRID offers customers and members of participating Blue Cross and Blue Shield plans a hassle-free opportunity to access more network dentists and discounts across the country.

This affiliation allows participating dentists to see members who were previously considered "out" of network as "in" network, with the plan payments going directly to the office rather than the member.

The national Dental GRID has two networks: GRID and GRID+.

GRID

- Access is available to Anthem Dental Prime members and members of other participating Blue Cross and Blue Shield Plans.
- Provider reimbursement is equivalent to Prime (PPO 100/Prime/Complete or PPO 200/Prime/Complete).
- Claims are processed "in" network when member is seen by a PPO 100/Prime/Complete or PPO 200/Prime/Complete dentist.
- Claims are processed "out" of network when member is seen by a PPO 300/Complete dentist.
  - PPO 300/Complete dentist may balance bill the member up to their submitted fees.
- Specialists are in network for members who access GRID.

GRID+

- Access is available to Anthem Dental Complete members and members of other participating Blue Cross and Blue Shield Plans.
- Provider reimbursement is equivalent to Complete (PPO 100/Prime/Complete, PPO 200/Prime/Complete, and PPO 300/Complete).
- Member may be seen by any dentist who participates in PPO 100/Prime/Complete, PPO 200/Prime/Complete or PPO 300/Complete.
- Claims are processed at your contracted fee.
- Specialists are in network for members who access GRID+.

Identifying a Member Who Can Access the GRID or GRID+ Network

- A participating plan will issue their own member ID cards indicating the plan name on the front of the card.
- A member's ID card will have either GRID **or** GRID+ on the **back** of their card.
- The Customer Service phone number of the participating plan and the Claims address of where to submit claims for these members will be on the back of the member's ID Card.

Member's coverage:

A participating plan's members receive in network benefits when being seen by dental providers outside of their local plan's service area when the plan participates in the GRID and the network level.

Claims Submission:

Claims are submitted to the plan's claims address, as listed on the back of the member's ID card.

Claims Payments:

Payments are made from the member's plan, directly to the treating dentist. The fee schedule used will be based on the treating doctor's location and participation in the PPO 100/200/300/Prime/Complete networks.

The GRID Dental Corporation is a separate company that provides dental network services on behalf of Anthem Blue Cross and Blue Shield, an independent licensee of the Blue Cross and Blue Shield Association.

PPO 100/200/300/Prime/Complete Plans/Products

The chart below compares reimbursement for the provider networks (PPO 100/200/300/Prime/Complete and GRID/GRID+) that our members may access.

Provider Participation Network Level					
Member / Group / Product		**PPO100/Prime/Complete, PPO200/Prime/Complete, PPO300/Complete, & GRID & GRID+**	**PPO200/Prime/Complete, PPO300/Complete, & GRID & GRID+**	**PPO300/Complete, & GRID+**	**SPECIALIST, & GRID & GRID+**
	100	In Network Pays at and Collect up to 100/Prime/Complete Allowed Amount	In Network Pays at 100/Prime/Complete, Collect up to 200/Prime/Complete Allowed Amount	In Network Pays at 100/Prime/Complete, Collect up to 300/Complete Allowed Amount	In- Network Pays at and Collect up to Specialist Allowed Amount
	200	In Network Pays at and Collect up to 200/Prime/Complete Allowed Amount	In Network Pays at and Collect up to 200/Prime/Complete Allowed Amount	In Network Pays at 200/Prime/Complete, Collect up to 300/Complete Allowed Amount	In- Network Pays at and Collect up to Specialist Allowed Amount
	300	In Network Pays at and Collect up to 300/Complete Allowed Amount	In Network Pays at and Collect up to 300/Complete Allowed Amount	In Network Pays at and Collect up to 300/Complete Allowed Amount	In- Network Pays at and Collect up to Specialist Allowed Amount
	100/200/300	In Network Pays at and Collect up to 100/Prime/Complete Allowed Amount	In Network Pays at and Collect up to 200/Prime/Complete Allowed Amount	In Network Pays at and Collect up to 300/Complete Allowed Amount	In- Network Pays at and Collect up to Specialist Allowed Amount
	Dental Prime	In Network Pays at and Collect up to 100/Prime/Complete Allowed Amount	In Network Pays at and Collect up to 200/Prime/Complete Allowed Amount	OUT OF NETWORK Balance Billing up to providers usual fee	In- Network Pays at and Collect up to Specialist Allowed Amount
	Dental Complete	In Network Pays at and Collect up to 100/Prime/Complete Allowed Amount	In Network Pays at and Collect up to 200/Prime/Complete Allowed Amount	In Network Pays at and Collect up to 300/Complete Allowed Amount	In- Network Pays at and Collect up to Specialist Allowed Amount

Wisconsin Provider Networks

All dentists who have signed a Participation Agreement for Anthem's PPO 100/200/300/Prime/Complete, Discount Program, Anthem Dental PPO, and Federal Employee Program networks are considered participating dentists to provide in network benefits to members.

Dental plan payments are made directly to a participating dentist. Payments are subject to the limitations, exclusions, deductibles, co-payments, and annual maximums of the member's dental benefit plan.

Anthem evaluates the allowances, under the member's dental plan, which may be made toward such treatment in accordance with covered benefits under the group contract, and the standards of generally accepted dental practices. Anthem does not interfere with the dentist's diagnosis or treatment plan.

The following pages include descriptions of the Anthem networks and the products they serve. Because there are different networks and coverage plans, it is extremely important that you ask a member for their identification card. Identification cards are not a guarantee of benefits or eligibility but will give you necessary information such as the type of plan, phone number to call for benefits and questions, as well as where to submit claims. Be sure to copy the front and the back of the member's identification card for future reference.

Traditional Provider Network

Anthem Dental PPO

The Anthem Dental PPO network is an established network that has been in service for years. This network is also referred to as our Traditional PPO network.

Any dentist who participates in the PPO network has the option to also participate in the FEP network.

Federal Employee Program (FEP)

The FEP network covers active and retired Federal Employees and their families.

The FEP network contains:

- Basic Option
- Standard Option

Dentists that participate in FEP accept both Basic and Standard Option.

Dental Health Maintenance Organization (DHMO)

Contact Professional Services at 1-866-947-9398 with questions regarding DHMO network participation, contract questions, or provider reimbursement amounts.

PPO 100/200/300/Prime/Complete

The PPO 100/200/300/Prime/Complete network is Anthem's newest network and is currently being marketed to commercial groups, ASO or fully insured employer groups and individuals.

General dentists may choose between three (3) levels of participation. Dentists choosing to participate in the 100/Prime/Complete level are also agreeing to participate in the 200/Prime/Complete and 300/Complete levels. Dentists choosing to participate in the 200/Prime/Complete level are also agreeing to participate in the 300/Complete level. Dentists choosing to participate in the 300/Complete level are only participating in the 300/Complete level.

Reimbursement is typically a combination of the plan payment and member payment that will equal up to the dentist's contracted allowed amount.

A specialist who participates in the Specialist network is considered participating in all three (3) levels and reimbursement is based on the specialist fee schedule.

Discount Program

The PPO 100/200/300/Prime/Complete Participating Dentist Agreement includes an addendum for those dentists that are interested in participating in the Discount Card Program. In order for a dentist to be eligible to participate in the Discount Card Program they must participate in the 200/Prime/Complete level and accept the 200/Prime/Complete fee schedule. The dentist must actively sign to participate in the Discount Card Program as the program has its own conditions for participation. It is typical for Discount Plans not to have any claims submitted to the plan for reimbursement as the payment for services rendered is received directly from the member at the dentist's contracted 200/Prime/Complete allowed amount at time of service. The dentist is responsible for requesting Discount Program identification material prior to providing services.

Dental Plans, Products or Dental Network Programs Using the PPO 100/200/300/Prime/Complete Networks

- **Dental Prime** = In-Network if participating in Wisconsin's PPO 100/Prime/Complete AND/OR PPO 200/Prime/Complete
- **Dental Complete** = In-Network if participating in Wisconsin's PPO 100/Prime/Complete AND/OR PPO 200/Prime/Complete AND/OR PPO 300/Complete ONLY
- **Dental GRID** = In-Network if participating in Wisconsin's PPO 100/Prime/Complete AND/OR PPO 200/Prime/Complete (Prime) as noted above
- **Dental GRID+** = In-Network if participating in Wisconsin's PPO 100/Prime/Complete AND/OR PPO 200/Prime/Complete AND/OR PPO 300/Complete ONLY (Complete) as noted above
- **Dental Blue (DB) PPO100, PPO200, PPO300** = In-Network if participating in Wisconsin's PPO 100/Prime/Complete AND/OR PPO 200/Prime/Complete AND/OR PPO 300/Complete ONLY

Note: Dental Plans/Products can have numerous designs as an employer can select what benefits they want to cover for their employees and at different percentage co-insurance levels (i.e. 100/80/50 – classic design).

GRID and GRID+

The national Dental GRID, administered by the GRID Dental Corporation, is one of the country's leading national dental networks.

The national Dental GRID offers customers and members of participating Blue Cross and Blue Shield plans a hassle-free opportunity to access more network dentists and discounts across the country.

This affiliation allows participating dentists to see members who were previously considered "out" of network as "in" network, with the plan payments going directly to the office rather than the member.

The national Dental GRID has two networks: GRID and GRID+.

GRID

- Access is available to Anthem Dental Prime members and members of other participating Blue Cross and Blue Shield Plans.
- Provider reimbursement is equivalent to Prime (PPO 100/Prime/Complete or PPO 200/Prime/Complete).
- Claims are processed "in" network when member is seen by a PPO 100/Prime/Complete or PPO 200/Prime/Complete dentist.
- Claims are processed "out" of network when member is seen by a PPO 300/Complete dentist.
  - PPO 300/Complete dentists may balance bill the member up to their submitted fees.
- Specialists are in network for members who access GRID.

GRID+

- Access is available to Anthem Dental Complete members and members of other participating Blue Cross and Blue Shield Plans.
- Provider reimbursement is equivalent to Complete (PPO 100/Prime/Complete, PPO 200/Prime/Complete, and PPO 300/Complete).
- Member may be seen by any dentist who participates in PPO 100/Prime/Complete, PPO 200/Prime/Complete or PPO 300/Complete.

- Claims are processed at your contracted fee.
- Specialists are in network for members who access GRID+.

Identifying a Member Who Can Access the GRID or GRID+ Network

- A participating plan will issue their own member ID cards indicating the plan name on the front of the card.
- A member's ID card will have either GRID **or** GRID+ on the **back** of their card.
- The Customer Service phone number of the participating plan and the Claims address of where to submit claims for these members will be on the back of the member's ID Card.

Member's coverage:

A participating plan's members receive in network benefits when being seen by dental providers outside of their local plan's service area when the plan participates in the GRID and the network level.

Claims Submission:

Claims are submitted to the plan's claims address, as listed on the back of the member's ID card.

Claims Payments:

Payments are made from the member's plan, directly to the treating dentist. The fee schedule used will be based on the treating doctor's location and participation in the PPO 100/200/300/Prime/Complete networks.

The GRID Dental Corporation is a separate company that provides dental network services on behalf of Anthem Blue Cross and Blue Shield, an independent licensee of the Blue Cross and Blue Shield Association.

PPO 100/200/300/Prime/Complete Plans/Products

The chart below compares reimbursement for the provider networks (PPO 100/200/300/Prime/Complete and GRID/GRID+) that our members may access.

Provider Participation Network Level					
Member / Group / Product		**PPO100/Prime/Complete, PPO200/Prime/Complete, PPO300/Complete, & GRID & GRID+**	**PPO200/Prime/Complete, PPO300/Complete, & GRID & GRID+**	**PPO300/Complete, & GRID+**	**SPECIALIST, & GRID & GRID+**
	100	In Network Pays at and Collect up to 100/Prime/Complete Allowed Amount	In Network Pays at 100/Prime/Complete, Collect up to 200/Prime/Complete Allowed Amount	In Network Pays at 100/Prime/Complete, Collect up to 300/Complete Allowed Amount	In- Network Pays at and Collect up to Specialist Allowed Amount
	200	In Network Pays at and Collect up to 200/Prime/Complete Allowed Amount	In Network Pays at and Collect up to 200/Prime/Complete Allowed Amount	In Network Pays at 200/Prime/Complete, Collect up to 300/Complete Allowed Amount	In- Network Pays at and Collect up to Specialist Allowed Amount
	300	In Network Pays at and Collect up to 300/Complete Allowed Amount	In Network Pays at and Collect up to 300/Complete Allowed Amount	In Network Pays at and Collect up to 300/Complete Allowed Amount	In- Network Pays at and Collect up to Specialist Allowed Amount
	100/200/300	In Network Pays at and Collect up to 100/Prime/Complete Allowed Amount	In Network Pays at and Collect up to 200/Prime/Complete Allowed Amount	In Network Pays at and Collect up to 300/Complete Allowed Amount	In- Network Pays at and Collect up to Specialist Allowed Amount
	Dental Prime	In Network Pays at and Collect up to 100/Prime/Complete Allowed Amount	In Network Pays at and Collect up to 200/Prime/Complete Allowed Amount	OUT OF NETWORK Balance Billing up to providers usual fee	In- Network Pays at and Collect up to Specialist Allowed Amount
	Dental Complete	In Network Pays at and Collect up to 100/Prime/Complete Allowed Amount	In Network Pays at and Collect up to 200/Prime/Complete Allowed Amount	In Network Pays at and Collect up to 300/Complete Allowed Amount	In- Network Pays at and Collect up to Specialist Allowed Amount

Claim Information

Section 3:

Claim Submission Tips & Signature Requirements

Claim Submission Tips

Submitting accurate claims results in faster payment.

To ensure timely claims payment, you may use the following checklist as a tool for submitting paper claims. Please check the information you are providing for completeness and accuracy.

- State-issued Dentist License Number and Tax Identification Number (TIN)
- Dentist's personal National Provider Identifier (NPI) Number
- Patient's birth date
- Patient's relationship to the member
- Member's birth date
- Member's social security number (SSN) or identification number
- Member/patient's signature
- Current ADA procedure code(s)
- Fee for treatment
- Treatment date(s)
- Tooth number, surface, and quadrant if applicable
- Dentist's signature

Signature Requirements

Anthem requires the signature (or "Signature on File") of the treating dentist and patient on all claim forms for payment.

All approved American Dental Association (ADA) claim forms provide areas for the signatures of the dentist and or the patient, parent, or guardian. Any staff person authorized by the dentist may enter the dentist's signature; a stamped facsimile of the dentist's signature is also acceptable. Whatever method is used, the dentist retains the responsibility for the accuracy of any claims submitted by his or her office.

For the convenience of participating dentists, Anthem will process claim forms for payment with the phrase **Signature on File** entered in the dentist and patient signature blocks. If you want to use this system, you should first obtain a release from your Anthem patients and retain the release in your files. The text of the release should be similar to the wording found in the patient signature block on the Attending Dentist's Statement. You do not need to notify Anthem before you begin to use the Signature on File system. Additionally, it is not necessary for you to send Anthem copies of any patient releases you may have obtained, as you are responsible for the accuracy of all information, which you submit on claims submitted in this manner.

Submitting Electronic Claims

How to Get Started

To send claims electronically you will need:

- To establish a relationship with a practice management vendor that allows for electronic claim submission using the rules in the Health Insurance Portability and Accountability Act 837D format;
- A computer with software for submitting claims and attachments; and
- Internet access so you may submit claims and receive electronic claim reports.

If you have questions or need assistance, contact your practice management software vendor. They can provide you with the necessary instructions for submitting claims electronically.

Anthem does not charge dental offices for electronic claim submissions. Your software vendor and the clearinghouse may charge you for submitting claims. Be sure to check with your software vendor.

Payer IDs

A payer ID is a five-character designator used to route your claim to the correct insurance carrier. Please check with your software vendor to confirm the number they want you to use.

Subscriber / Patient Information

Before submitting a claim, review and verify that you have current subscriber and patient information. Pay particular attention to the subscriber's ID number, subscriber's date of birth, and their address. For the patient be sure to use the correct spelling of their name and use their correct date of birth. Anthem uses this information to ensure a claim is processed under the correct individual's record.

The subscriber's ID number can be found on their ID card.

Provider Information

It is important to submit complete and accurate provider information to ensure claim messages and payments are directed to the correct provider.

- **Send the Servicing/Treating Provider National Provider Identifier (NPI).** The clinic or corporate NPI may be included, but the treating provider's NPI is needed.
    - Claims submitted without a valid NPI may be rejected.
- Send the Servicing/Treating provider's full license number as it is shown on their state-issued dental license.
- Include Servicing/Treating Provider TIN.
- Servicing/Treating Provider Name.
- Billing Address, where the payment should be mailed

Claim Radiographs (X•Rays)/Attachments

Most claims do not require the submission of x-rays or attachments. Before sending x-rays or attachments, please review the Dental Claim Attachment Requirements, or submit the claims without attachments. We will request any x-rays/attachments if needed.

When x-rays are needed they may be submitted electronically using an electronic attachment vendor, National Electronic Attachment (NEA)*.

X-ray images or other attachments may also be sent via Anthem's web site application. Available delivery methods for x-rays/attachments are:

- National Electronic Attachment, Inc. (NEA);
- Mail – use the address listed on subscriber's ID card; or
- Web – Anthem web portal - powered by Availity – https://www.availity.com.

Note: *Regardless of the method used to submit attachments, it is important to include the attachment/paperwork number on the electronic claim submission and the corresponding attachment cover sheet.*

- *When NEA is used, NEA will provide an attachment reference number; use this number on the electronic claim. An attachment cover sheet is not needed upon submission.*
- *When submitting by mail you must complete an attachment cover sheet. The attachment/paperwork reference number you assign should be a unique number that allows you to identify and connect the information to a specific patient's record. The same number must be used on both the electronic claim and the attachment cover sheet.*
- *When submitting by Web for Prime and Complete, the information entered is the attachment cover sheet. The attachment/paperwork reference number you assign should be a unique number that allows you to identify the information to a specific patient's record. Enter the attachment/paperwork reference number submitted on the electronic claim on the Web screen.*

Failure to provide the same number on the electronic claim and the attachment cover sheet may result in claim delays or denials because we will not be able to match the claim with the attachment(s).

*NEA develops and markets Internet based solutions in support of electronic claims. If you do not currently utilize NEA you may obtain additional information at www.nea-fast.com.

Claims with Coordination of Benefits

When a patient is covered by more than one insurance plan, the patient may be entitled to Coordination of Benefits. If Anthem is the secondary payer, the claim should include the amount paid by the primary payer. If this amount is not included on the claim, the claim may be denied and the primary payment information requested.

If a patient is covered under two different group insurance plans that are both administered by Anthem, you may submit the claims electronically. You should first submit the claim using the subscriber's ID with the primary group coverage. Once payment has been made, you may submit the claim electronically under the subscriber's ID with the secondary coverage. Include the primary plan payment on the secondary claim that is submitted.

Pre•treatment Estimates

Submit a pre-treatment estimate by omitting the dates of service on a paper or electronic claim. Omitting the dates on a paper or electronic claim indicates that services have not been rendered and the submission will be processed as a pre-treatment estimate.

Claims that are Rejected

Anthem automatically sends claim status messages to the submitter upon receipt of an electronic claim. The messages indicate the acceptance or rejection of a claim. For claims that are accepted, Anthem will return additional messages indicating the status of the claim. Insufficient information may result in a claim being rejected. Claims that are rejected do not create any other response or output (we do not issue an Explanation of Benefits (EOB)). If a claim is electronically rejected by Anthem for missing or invalid information, make the appropriate corrections on your system and resubmit the claim as directed. Anthem's system automatically rejects/denies claims that are exact duplicates of a claim that was previously submitted. If you need to submit changes to a claim that was previously submitted and accepted, refer to Replacement and Void Claim transactions noted below.

Submitting a Replacement Claim Transaction

Electronic claims are sent with an identifier that indicates if a claim is an Original submission, a Replacement of a claim previously submitted, or a transmission to void a previous claim submission. A claim submission should be identified as a Replacement when:

- Adding services,
- Changing procedure code(s), and/or
- Correcting date(s) of service

Submitting a Void Transaction

Electronic claims are sent with an identifier that indicates if a claim is an Original submission, a Replacement of a claim previously submitted, or a transmission to void a previous claim submission. Identify the claim as a void transaction when changing:

- Payer ID,
- Subscriber,
- Billing provider, and/or
- Rescinding the claim because the patient did not want insurance billed.

If a new claim will be sent to replace the voided claim, send the void transaction first and wait a few days before submitting the new claim. This will ensure proper handling of both the voided transaction and new claim.

Submitting an Appeal

Appeals to claim determination should be submitted in writing to the Appeals department:

Prime and Complete Claims:
Anthem
Attn: Dental Claims Appeals & Grievances
PO Box 1122
Minneapolis, MN 55440-1122

Other Anthem PPO Claims:
Anthem Dental
PO Box 659444
San Antonio, TX 78265

Electronic Claims Transmission Reports

You will receive reports from both your clearinghouse and from Anthem. The reports provide confirmation that your claim(s) were sent by the clearinghouse and if Anthem received and accepted or rejected the claim(s). Anthem sends an Electronic Claims Transmissions Report that lists claims we received and accepted. The report provides what action has occurred on each individual claim. Below is a summary of key information included on the Electronic Claim Transmission Report.

- Insured's ID – The subscriber's ID that was provided on the claim.
- Claim Date – The date the provider sent the claim.
- Received Date – The date Anthem received the claim from the clearinghouse.
- Claim Amount – The total dollar amount for all services submitted on the claim.
- Patient Name – The name of the patient provided on the claim.
- Claim ID – The plan number and the claim number assigned when we received the claim.
- Results – A brief description of the actions taken on the claim. If the claim has not been adjudicated, additional updates will appear on future reports. Once the claim has adjudicated, the message will read "EOB to follow".
- Description – A brief explanation of why a claim has not been adjudicated. This field only appears on the report if a determination has not been finalized.
- Action – A brief description of steps that you may be required to take before the claim can be adjudicated and finalized.

Who to Contact with Questions

Please use the following guidelines to determine who to contact with questions:

- If a claim is rejected at the clearinghouse level, contact the clearinghouse.
- If Anthem rejects a claim, contact your clearinghouse to help understand the reason for the rejection.
- If a claim you have sent does not appear on the transaction report, call the clearinghouse.
- If you have not received your Electronic Claim Transmission Report(s), call the clearinghouse for more information.
- If you have a question about the status of a claim, you may access Anthem's website at https://www.anthem.com/provider/dental/ or contact Customer Service using the telephone number listed on the patient's ID card. When calling, please inform the customer service representative that the claim was sent electronically.
- If you have questions concerning claim level reimbursements, available benefits, or a denial of benefits, contact Customer Service using the telephone number listed on the patient's ID card.

Quality Assurance

Section 4:

Dentist Credentialing and Re-credentialing

The goal of Anthem is to establish long-term relationships with dentists who share our commitment to continuously improving the lives of our members.

Credentialing refers to the process of screening, making fair approval decisions and the continuous evaluation of a network dentist's ability to meet specific participation requirements.

The credentialing and re-credentialing process provides assurances to employer groups, consumers and regulators that our participating dentists meet minimum standards.

Along with signed participating provider agreements, each new dentist must provide the following credentialing elements:

- A completed Credentialing Application that includes answering disclosure questions, and confirmation of professional liability insurance including limits and expiration date.
  - ✓ Note: Some states require a state-specific or the CAQH credentialing application be used, please ensure you are using the correct application for the state you are practicing in.
- A copy of a current dental license for each state in which the dentist practices.
- A copy of a current DEA for each state in which the dentist practices, if the dentist holds such a registration.
- A copy of the specialty certificate (if applicable).
- Written verification of the dentist's National Provider Identifier (NPI) number (individual and/or clinic).
- A completed W9 form indicating the appropriate Tax Identification Number (TIN) or Social Security Number (SSN) used to submit claims.

Dentists are initially credentialed based on contract participation requirements. Dentists are re-credentialed on a regular basis depending on the re-credentialing requirements for the various contracts. In addition, verification with sources such as Medicare/Medicaid, Office of Inspector General, and state dental boards are performed as part of the credentialing and re-credentialing process.

All information obtained as part of the credentialing or re-credentialing process is treated confidentially by Anthem.

A dentist is not considered a participating provider and added to a network until all participation and credentialing requirements are met.

Grievance Resolution

Anthem is committed to member satisfaction and quality care. Our commitment is demonstrated through a formal grievance resolution program that promptly addresses members' concerns regarding administration, quality of care and network specific issues.

A participating dental office should provide both a level of patient care and open communication to facilitate the immediate internal resolution of patients' concerns. Matters, which cannot be satisfactorily answered or concluded within the dental office, will be resolved through the formal grievance procedures established by Anthem. Participating dentists shall comply and provide all necessary documentation to resolve patient grievances, complaints and/or inquiries. A participating dentist agrees to cooperate in resolution of a quality of care grievance and comply with the requirements of any applicable state or federal law or regulation governing grievances. It is expected that a participating dentist will cooperate fully in Anthem's investigation of all grievances.

Anthem will make every reasonable effort to resolve grievances within 30 days of receipt or as required by state law or contract. If resolution cannot be made within 30 days of receipt members will be notified that additional time may be needed.

Professional Review

Section 5:

Claims Review Submission Guidelines – Anthem Dental PPO and 100/200/300/Prime/Complete

For claims submission, one or more of the following procedures may be reviewed based on identified patterns of practice using historical claims data and/or review of procedures dictated by dental plans for accurate benefit administration.

These guidelines reference Legacy and Prime and Complete submission requirements and Anthem Clinical Policies where applicable.

Submission of Radiographic Image Requirements:
Patient identifier, Current (within 12 months), dated, mounted, properly labels and oriented diagnostic (sufficient contrast and density, no geometric distortion) radiographic images.

- All periapical radiographic images must show the entire tooth structures (crown and root including the apex).

Procedure Code	Description	Send with Claim/Pre-Determination
RESTORATIVE PROCEDURES		
D2390	Resin Crown	Dated pre-operative x-rays.
D2510 – D2664	Inlays/Onlays	Prior placement date, dated pre-operative x-rays including bitewings. Dated periodontal charting, if applicable.
D2710 – D2799	Crowns	Prior placement date, dated pre-operative x-rays including bitewings, if applicable. Date periodontal charting, if applicable.
D2710 – D2799	Crowns specific to third molars	Prior placement date, dated pre-operative x-rays including bitewings, if applicable. Date periodontal charting, if applicable.
D2930 – D2934	Crowns (Stainless Steel)	Dated pre-operative x-rays.
D2940	Protective Restoration	Dated pre-operative x-rays and chart notes.
D2950, 2951	Build-ups, pins	Dated pre-operative x-rays, and rationale for dental necessity, if applicable.
D2952 – D2957	Posts and core	Dated pre-operative x-rays, and rationale for dental necessity, if applicable.
D2960 – D2962	Veneers	Prior placement date, dated pre-operative x-rays, including bitewings, if applicable. Dated periodontal charting, if applicable.
D2980 – D2983	Crown Repair	Dated pre-operative x-rays.
ENDODONTIC PROCEDURES		
D3220 – D3240	Endodontic Therapy	Dated pre-operative x-rays.
D3310 – D3348	Endodontic Therapy	Dated pre and post-operative x-rays.
D3351 – D3353	Apexification/Recalcification	Dated pre-operative x-rays.
D3355 – D3357	Pulpal Regeneration	Dated pre-operative x-rays and chart notes.

Procedure Code	Description	Send with Claim/Pre-Determination
D3410 – D3450	Apicoectomy/Periradicular Surgery	Dated pre-operative x-rays.
D3470	Reimplantation	Dated pre-operative x-rays.
D3920	Hemisection	Dated pre-operative x-rays.
PERIODONTIC PROCEDURES		
D4210 – D4211	Gingivectomy	Dated Periodontal charting (pre and post root planing), pre-operative Full Mouth x-rays, progress or chart notes, narrative including dates of pre-operative root planing, intra-oral photographs, if applicable.
D4212	Gingivectomy/Gingivoplasty	Dated pre-operative x-rays and chart notes/narrative.
D4240 – D4245	Flap procedures	Dated Periodontal charting (pre and post root planing), pre-operative x-rays, progress or chart notes, narrative, including dates of pre-operative root planing.
D4249, D4268	Crown Lengthening	Dated Periodontal charting, Dated pre-operative x-rays, chart notes/narrative.
D4260 – D4261	Osseous Surgery	Dated Periodontal charting (pre and post root planing), pre-operative Full Mouth x-rays, progress or chart notes, narrative including dates of pre-operative root planing.
D4263 – D4264	Bone Grafts	Dated Periodontal charting, Dated pre-operative x-rays, progress or chart notes.
D4265 – D4267	Tissue Regeneration	Dated Periodontal charting, Dated pre-operative x-rays, progress or chart notes.
D4274	Distal Wedge Procedure	Dated Periodontal charting, Pre-operative x-rays, chart notes.
D4270 – D4285	Tissue Grafts	Dated Periodontal charting showing attachment levels, recession (in millimeters), and amount of attached keratinized gingiva (in millimeters); intraoral photographs.
D4341 – D4342	Scaling and Root Planing	Dated Periodontal charting, Dated pre-operative x-rays, progress or chart notes; for 4 quadrants the amount of time performed.
D4355	Full Mouth Debridement	Dated pre-operative x-rays and chart notes.
D4381	Local Delivery Antimicrobial Agent	Dated Periodontal charting; history of periodontal therapy.
D4910	Periodontal Maintenance	Dated Periodontal charting, if applicable. Chart notes/narrative regarding history of periodontal therapy.
REMOVABLE PROSTHODONTICS		
D5110 – D5140, D5211 – D5226, D5281	Complete and Partial Denture Placement	Prior placement date, dated pre-operative x-rays. Chart notes and dated periodontal charting, if applicable.
D5410 – D5761	Additional Denture Codes	Narrative for necessity.
D5982	Surgical Stent	Chart notes. Narrative for necessity.

Procedure Code	Description	Send with Claim/Pre-Determination
IMPLANT PROCEDURES		
D6010 – D6199, D3460	Implant Procedures	Dated pre-operative full mouth x-rays, dated periodontal charting.
D6190	Radiographic/surgical implant index	Narrative for necessity, progress or chart notes.
FIXED PROSTHODONTICS		
D6205 – D6794	Bridge procedures	Prior placement date, dated pre-operative full mouth x-rays, dated periodontal charting.
D6290 – D6999	Bridge repairs & Misc. Procedures	Dated pre-operative x-rays and chart notes/narrative.
ORAL AND MAXILLOFACIAL SURGERY PROCEDURES		
D7210 – D7251	Surgical Extraction	Pre-Determinations: Dated pre-operative x-rays, treatment notes detailing dental necessity. Claims: Dated pre-operative x-rays and detailed chart notes describing surgical procedure performed.
D7260 – D7283, D7287 – D7291	Other Oral Surgery Procedures	Dated pre-operative x-rays and chart notes.
D7270 – D7272	Reimplantation/Transplantation	Dated pre-operative x-rays.
D7285 – D7286	Biopsies	Pathology Report; x-rays if appropriate.
D7310 – D7321	Alveoloplasty	Dated pre-operative x-rays; narrative and progress notes.
D7410 – D7461	Surgical Excision (soft tissue)	Chart notes.
D7471 – D7490	Surgical Excision (hard tissue)	Dated pre-operative x-rays and chart notes.
D7510 – D7521	Incision and Drainage	Dated pre-operative x-rays and detailed chart notes describing surgical procedure performed and location.
D7530 – D7560	Surgical Incision	Dated pre-operative x-rays and chart notes.
D7810 – D7877	TMJ Surgery	No materials needed.
D7880 – D7881	Occlusal Device	Medical coverage information, narrative for necessity.
D7899	Unspecified TMD therapy by report	Diagnosis and detailed chart notes describing the therapy proposed/rendered.
D7920 – D7951, D7970 – D7996	Other surgical repairs	Dated pre-operative x-rays and chart notes.
D7953	Bone Graft	Dated pre-operative x-rays, progress or chart notes as applicable.
D7960 – D7963	Frenulectomy/Frenuloplasty	Chart notes.
ORTHODONTICS (MEDICALLY NECESSARY ORTHODONTIC CARE)		
D8030 – D8090	Medically Necessary Orthodontic Treatment	Completed HLD Index Form (found on our website), orthodontically trimmed study models with wax bites or ortho cadcam electric equivalent including all views, orthodontic treatment plan, when appropriate, surgical treatment plan and letter of medical necessity.

Procedure Code	Description	Send with Claim/Pre-Determination
ADJUNCTIVE SERVICES		
D9120	Fixed partial denture sectioning	Dated pre-operative x-rays and chart notes.
D9223	Deep sedation/General Anesthesia	On the same claim form, submit procedures performed on the same date of services that the sedation/general anesthesia was performed. If the procedures were provided by another practitioner, include these procedures in the "Remarks" (Section 35) of the claims form. Complete anesthesia record indicating start and stop times of anesthesia.
D9243	IV Conscious Sedation	On the same claim form, submit procedures performed on the same date of services that the sedation/general anesthesia was performed. If the procedures were provided by another practitioner, include these procedures in the "Remarks" (Section 35) of the claims form. Complete anesthesia record indicating start and stop times of anesthesia.
D9610, D9630	Other Drugs/Medications	Narrative and progress notes.
D9920 – D9930	Behavior Management	Chart notes.
D9940	Occlusal Guards	Chart notes.
D9951 – D9952	Occlusal Adjustments	Chart notes.

Appeal Process

In the event a claim is denied in whole or in part, a patient and dentist shall have the right to a full and fair review. Dentists may submit an appeal on their own behalf or on behalf of a patient if the patient has authorized the submission of an appeal.

A request to review a claim may be submitted in writing, or verbally by calling Customer Service. Requests must be submitted within 180 days from the claim denial. An appeal must include the patient's name, patient's identification number, group number, claim number and dentist's name as shown on the Explanation of Benefits (EOB). Send appeals to the address shown on the EOB.

Written comments, documents, or other information should be submitted in support of an appeal. Appealed claims are to include additional information from the treating dentist that could describe the services, underlying conditions and unique circumstances of the treatment and should serve as the basis for the appeal. If no new information is provided, the initial denial will remain. Appeals should be accompanied with the appropriate diagnostic information, even if submitted initially, and the original Anthem pre-estimate or EOB.

For Prime and Complete Only:

Acknowledgement of receipt of an appeal will be issued within 3 days of receipt. A benefit determination will be made within 30 days following receipt of an appeal. In some cases, the timeframe to review an appeal may be extended.

The original decision-maker will not conduct appeal review. A second person will review the appeal without deference to the initial decision. All benefit determinations are based on a preset schedule of dental services eligible under the patient's plan. Claims are not reviewed to determine dental necessity or appropriateness. Dental professionals who have appropriate training and experience will be consulted in all cases where professional judgment is required to determine if a procedure is a covered service under the patient's Anthem plan schedule-of-benefits.

Compliance Program

Section 6:

Compliance Program

Compliance with the Participating Dentist Agreement and our network requirements is necessary for the proper administration and servicing of Anthem's networks and the various dental programs they service.

Examples of Non•Compliance

Some examples of non-compliance include, but are not limited to:

- Misrepresentation of dates of dental service, services performed, or fees charged on a claim form.
- Misrepresentation of usual, customary, and reasonable charged fees.
- Waiver of applicable contract co-payments or deductibles.
- Other types of activities involving claim forms or fee data which result in inaccurate information being submitted.
- Any other type of activity that amounts to insurance fraud.
- Any type of misconduct as determined by applicable state, county, or local dental society or other licensing authorities, which results in the loss or suspension of a license to practice dentistry.
- More than one formal disciplinary action of the same or similar type by a State Board of Dentistry or licensing authority, or a criminal conviction for sexual misconduct of any type, fraud, or any other felony or gross misdemeanor.

Compliance Investigation Procedures

When non-compliance is identified, all relevant documents and information may be examined by the appropriate staff of the Compliance areas within Anthem and a complete investigation of the matter may be conducted.

If non-compliance is verified, the participating dentist will be notified in writing of the facts and Anthem's requested corrective action. The requested corrective action may include, but is not limited to payment of subscriber or patient refunds, payment of refunds to Anthem, and written dentist certification that requested action items have been corrected. Follow-up provider audits may be performed to verify compliance with requested action and to monitor future compliance.

Whenever it is determined that a dentist must refund Anthem or other payer as a result of dentist's non-compliance or as a result of duplicate or erroneous claim payment, Anthem may, upon prior written notice to the participating dentist, deduct from any payments due the participating dentist, the amounts as reasonably determined to be due and owing, as a refund of payments incorrectly made to or claimed by the participating dentist. When this occurs, Anthem will notify the dentist of the amounts credited by individual patient accounts. The dentist must reflect the payments as credits on the patient's account.

Non-compliance with the Participating Dentist Agreement and network participation requirements is grounds for termination of participation and notification, when required, to appropriate regulatory entities, including but not limited to, the State Board of Dentistry, the NPDB and/or HIPDB.

Fraud and Abuse

All participating dentist's claim submissions are subject to review and/or audit for possible fraud, waste and abuse (FWA). Prevention and detection of FWA is in accordance with applicable State and Federal law.

Anthem Dental recognizes the importance of preventing, detecting, and investigating fraud, waste and abuse, and is committed to protecting and preserving the integrity and availability of health care resources for our recipients, clients, and business partners. Anthem Dental accordingly maintains a comprehensive program to combat fraud, abuse, and waste in the healthcare industry.

These responsibilities are delegated to Anthem's fraud, waste and abuse department whose mission is to combat fraud, waste and abuse in addition to investigating misrepresentation of services against various Anthem commercial and government plans. These responsibilities ensure the integrity of publicly-funded programs.

Right to Audit

The Dentist Provider shall keep and make available for examination and audit at Anthem Dental's request all clinical records and all substantiating documents supporting dental treatment including, but not limited to: all past and current radiographic images, all past and current chart or treatment records, all past and current laboratory prescriptions and invoices, all past and current treatment plans, office schedules and all financial records. An internal office audit may be necessitated dependent upon the findings of the audit. If an internal audit is requested, it must be accomplished during normal business hours and satisfied within 45 days of the request by Anthem Dental. The Dentist Provider will be informed of the results of the audit.

Dependent upon the audit findings, the Dentist Provider may be placed into a Pre-Payment Review Program (PPR). In the event the Dentist Provider is placed into the PPR program, all relevant clinical documentation will be requested to determine justification of the dental service prior to payment. When the Dentist Provider is placed into the PPR program, removal from the program occurs at Anthem Dental's discretion. All relevant documentation includes, but is not limited to, all clinical and financial documentation that substantiates dental treatment. Failure to comply with the program may lead to network termination.

Definitions

Fraud is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain by false or fraudulent pretenses, representations, or promises any of the money or property owned by, or under the custody or control of, any health care benefit program. Fraud is the intentional deception or misrepresentation of facts resulting in unauthorized benefits, payments or gains to an individual or entity.

Abuse includes actions that may, directly or indirectly, result in: unnecessary costs, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are dentally or medically unnecessary and payable by a commercial program, Medicaid or any other governmental agency program or health plan sponsor. Abuse is the receipt of payment for items or services when there is no legal entitlement to that payment, and the recipient of said payment has not knowingly and intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

Waste is the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs. Waste is generally not considered to be caused by negligent actions but rather the misuse of resource.

Administration

Section 7:

HIPAA Information

The Health Insurance Portability and Accountability Act (HIPAA) was signed into law in 1996. The goals of this federal law (and its related regulations) included protecting confidential patient data and reducing the cost of health care by standardizing electronic transactions. The HIPAA regulations that may impact dental providers cover the following topics:

- Electronic Transactions
- Patient Privacy
- Security of Patient Data
- National Identifiers
- Provider responsibility in the event of misrouted PHI

IMPORTANT: Only those providers who transmit a HIPAA-governed electronic transaction (that is, electronic claims submission) are subject to its regulations regarding electronic transactions.

HIPAA Regulations

Electronic Data Interchange (EDI)

HIPAA dictates uniform standards for certain health care EDI transactions. If providers conduct any of the specified transactions electronically (electronic claims submission, for example), they must do so in the standard format, or verify that their clearinghouse is doing so.

Privacy

The Privacy regulation requires written policies and procedures (and training of all staff members) so that access to patient data is restricted and storage of patient data is safeguarded appropriately. Affected providers must also make available a Notice of Privacy Practices to every patient and appoint a Privacy Officer for their organization. Business Associate agreements, however, are not required between providers and claims payers.

Security

HIPAA mandates uniform standards to protect confidential health information in electronic form. All providers who submit electronic claims must comply by implementing technical, administrative and physical safeguards. Technical safeguards pertain to computer and electronic data security, and physical safeguards pertain to building and room security. Administrative safeguards require written policies and procedures governing data security.

National Provider Identifier (NPI)

In order to uniquely identify every provider, HIPAA requires that every U.S. health care provider who bills for services obtain an NPI. This number becomes the primary means for provider identification, and is required on all electronic transactions nationwide. See page titled “National Provider Identifier (NPI)” for more details.

Misrouted Protected Health Information (PHI)

Providers and Facilities are required to review all member information received from Anthem to ensure no misrouted PHI is included. Misrouted PHI includes information about members that a Provider or Facility is not currently treating. PHI can be misrouted to Providers and Facilities by mail, fax, email, or electronic remittance. Providers and Facilities are required to immediately destroy any misrouted PHI or safeguard the PHI for as long as it is retained. In no event are Providers or Facilities permitted to misuse or re-disclose misrouted PHI. If Providers or Facilities cannot destroy or safeguard misrouted PHI, Providers and Facilities must contact Customer Service or call the number listed on the documentation received to report receipt of misrouted PHI.

HIPAA 5010

HIPAA 5010 standard is a federal directive mandated by the Health Insurance Portability and Accountability Act (HIPAA). This standard seeks to enhance the consistency and usage of transactions handled through Electronic Data Interchange (EDI). The implementation of the X12 version 5010 standard transactions brings better automation to your electronic submissions.

Your Practice Management vendor should be aware of these upcoming changes. Your office should also be receiving communication or updates from your Practice Management vendor.

Launch of dedicated 5010 webpage on EDI website

Recently, a webpage was launched to help keep you and our electronic trading partners informed about our 5010 activities, timelines and current updates. Here's what you'll find on the webpage:

- News and updates about our ongoing progress, as we work to comply with the new HIPAA 5010 requirements
- Frequently asked questions from the provider community along with detailed responses
- Online registration – Capability to sign up to receive e-mail alert messages and important updates regarding HIPAA 5010
- Online functionality to contact us via e-mail with prompt responses to your e-mails

To access our HIPAA 5010 web page, simply visit **www.anthem.com/edi**, and select your state. On the EDI page, select the Communication tab and select 5010.

We encourage you to visit the webpage often, and sign up to receive e-mail alert messages. If you plan to have your electronic vendor or clearinghouse to implement HIPAA 5010 changes on your behalf, we suggest that you urge them to register for e-mail alert messages as well.

National Provider Identifier (NPI)

On January 23, 2004, the federal government issued a Health Insurance Portability and Accountability Act (HIPAA) regulation. It is the National Provider Identifier (NPI) regulation, which establishes one unique identifier for each health care provider and eliminates the multiple identifiers currently in use.

The NPI regulation offers several advantages, including:

- One unique provider identifier for all health plans and payers to utilize
- A permanent provider identifier that will not change in the event of practice relocation
- An easier process for health plans to track claims payment and avoid duplication

The NPI is a random ten-digit number (nine digits plus a check digit to detect keying errors). It never expires. It contains no inherent information about the provider, such as state of residence or license number. NPI numbers are administered by the Centers for Medicare and Medicaid Services (CMS), which has contracted with the National Plan and Provider Enumeration System (NPPES). The federal government is also responsible for assisting providers in completing the application and resolving problems associated with an NPI.

The broad definition of health care "provider" in the NPI regulation encompasses all who provide health care services:

- Individuals – such as physicians, dentists and pharmacists and
- Organizations - such as hospitals and clinics

Although dental assistants and hygienists are "providers" and are thus eligible to obtain an NPI, they are only required to do so if they submit claims for their services.

All providers are eligible to receive an NPI. However, only "Covered Entities" are required to obtain an NPI. A dental provider is a "Covered Entity" if he or she transmits electronic transactions governed by HIPAA, primarily electronic claims. Clearinghouses are also required to be able to accept and transmit the NPI by May 23, 2007.

Providers who submit only paper claims may not be required to submit an NPI on their claims. However, Anthem strongly encourages the use of the NPI to ensure claims processing accuracy as some states have started to require the NPI on paper claims in addition to electronic claims. The most current ADA claim form includes a place to provide an NPI.

The NPI **does not replace** numbers used for purposes other than general identification, such as:

- Social Security Number
- DEA number
- Taxpayer ID number
- Taxonomy number
- State license number

There is no cost to apply for an NPI. Paper applications are available. Call NPPES to have an application sent. Call 1-800-465-3203 or TTY 1-800-692-2326.

Providers must communicate (to NPPES) any changes to the information collected during the application process within 30 calendar days of the change. Even if a provider changes location or specialty field, the NPI itself will never change.

Other health and dental plans will distribute communications regarding the use of NPI. But the same NPI is used when submitting claims to any payer. Providers need to notify all payers as to their NPI numbers.

Resources

The Federal Government's HIPAA Web Site
http://www.hhs.gov/ocr/privacy/index.html

NPI Application Help
https://nppes.cms.hhs.gov/NPPES/Help.do?topic=

The American Dental Association's NPI Web Page
http://www.ada.org/en/member-center/member-benefits/practice-resources/dental-informatics/electronic-health-records/health-system-reform-resources/national-provider-identifier

Updating Dentist and Dental Office Information

As a participating dentist, it is important for you to inform Anthem of any changes to your practice. This information is vital for accurate claims processing and payment. Changes must be submitted via fax, email, or mail. Update requests (provider change forms (see below), or letter) will be reviewed to ensure all necessary documentation is present and complete. A Provider Network representative will contact you if additional clarification is required.

Provider Change Forms:

- *Standardized Provider Maintenance Form* - A fillable PDF form, available on our website www.anthem.com/provider/dental/, or by contacting Provider Network Representative Services to email, or fax it to you. We have forms for all of types of changes listed below. You will fill out and submit a *General Office Information Form* with each change (only one *General Office Information Form* is needed if submitting multiple changes). This may be submitted to us via fax, email or mail.

NOTE: *Standardized Provider Maintenance Form* can be found on our website, located at www.anthem.com/provider/dental/. Please notify Anthem in writing via fax, email or mail when any of the following changes/updates occur to your practice:

As a general guideline, effective dates for changes cannot be guaranteed. Please contact Provider Network Representative Services for confirmation of an effective date.

Address Change (Change practice address, or phone/fax number)

When a change of address is anticipated, the dental office needs to notify Anthem prior to the effective date of changes*. The update request should indicate:

- Office name
- Old address
- New address
- Tax Identification Number (TIN)
- Names of all dentists the change applies to
- Effective date of the change*
- Any other information that will change such as phone number, fax number, office hours, emergency number, billing address, correspondence address, contact name, or languages spoken by office staff.

Add a New Location (s)

When an additional office location(s) is being established, Anthem needs to be notified prior to the effective date of the office opening. The update request should indicate:

- Office name
- TIN
- Physical address
- Billing address
- Correspondence address
- Names, license numbers, and employment status (owner, partner, or associate) of all dentists that will be participating at the new office

NOTE: If the office was purchased from another dentist, if another dentist will continue working at the office as a separate business, or if the location was previously a dental office, please review the information under "ownership changes," and contact Provider Network Representative Services to discuss your change further.

Tax Identification Number (TIN)/IRS Name Changes

If the business entity name and/or TIN change, the dentist must notify Anthem prior to the effective date of the change. The update request should indicate:

- Previous office name (if applicable)
- New office name (if applicable)Previous TIN
- New TIN
- Office address(es) this change applies to
- Names, license numbers, and employment status (owner, partner, or associate) of all dentists this change applies to.

NOTE: A new W9 form is also required. If you do not have a W-9 form, contact the Provider Network Representative Services department to request this form be sent to your office.

Change of Ownership

If you are adding a new location that was purchased from another dentist, or if the location was previously a dental office and operated under a different TIN, Anthem must be notified prior to the effective date of the change. Ownership change requirements may vary in each individual scenario, however in most cases the update request from the current or new owner should indicate:

- Previous owner's name
- Previous business name
- New owner's name
- New business name
- Previous TIN
- New TIN
- Office address(es) this applies to
- Names, license numbers, and employment status (owner, partner, or associate) of all dentists this change applies to
    - New dentists practicing under the new ownership may need to be credentialed before being considered participating dentists. Provider Network Representative Services will contact you if this is necessary for any dentists mentioned in the letter.

NOTE:

- **A new W9 form is also required**. If you do not have a W-9 form, contact the Provider Network Representative Services department to request this form be sent to your office.
- **New network agreements may also be required**. Please contact Provider Network Representative Services before submitting documentation to verify if this is a requirement in your specific situation.

Adding New Dentist(s) – New or existing location

When a new dentist joins the office and needs to be listed as a participating dentist, Anthem needs to be notified prior to the date the dentist begins practicing at the office. The update request should indicate:

- New dentist's full name, employment status at the office (owner, partner, or associate), license number, and individual NPI number
- Confirmation if he or she should be contracted with the same networks as the existing dentists.
- Office address
- TIN the dentist is to be listed under.

NOTE: Adding a new dentist to your office may require additional paperwork, such as signing a network agreement, credentialing application, completing a W-9, or providing credentialing documents. Contact the Provider Network Representative Services department for assistance in obtaining the correct information for your office.

Remove a Provider from a Location - Dentist(s) leaves a practice, retires, no longer practices due to medical or other reasons, or is deceased

When an existing dentist at the practice either retires, is no longer working at the practice, or passes away, Anthem needs to be notified. Updating Anthem with this information will avoid unnecessary mailings to your office, as well as keep the directories accurate. The update request should indicate:

- Dentist's full name
- Dentist's license number(s) and state(s) licensure
- Office address(es) this applies to
- Tax identification number(s) (TIN[s]) this applies to
- Reason for this request (no longer at this location, retired, or deceased)

How to complete a W•9 Form

A Tax Identification Number (TIN) is registered with the Internal Revenue Service (IRS) under the name of the person or the corporation of the dental practice. This name can be known as:

- The Business Entity
- Legal Name
- IRS Name

There can be only one IRS name per TIN, even if multiple dentists are working under the same TIN. All information listed on the W-9 form must match what has been filed with the IRS. Information listed on claims must match what is listed on the W-9 form.

If the W-9 form does not match what was filed with the IRS, there may be issues with your 1099 at the end of the year.

If the information submitted on claims does not match the W-9 form there may be claim issues. (e.g. claims may process as non-participating and the payments may go to the member rather than the dental office.)

NOTE: ***Calling Anthem with a change or showing an office change on a claim will NOT result in the updating of the dentist's information. Separate written notice is required.***

Updated dentist and dental office information may be emailed, faxed, or mailed to:

Email: DentalNetworkServices@anthem.com

Fax: 1-877-283-1331

Mail To:
Anthem Blue Cross and Blue Shield
PO Box 640
Minneapolis, MN 55440

Provider Network Representative Services can be contacted by dentists from any state at 1-866-947-9398.

How Anthem Communicates

Anthem has important information available online that assists our providers in obtaining information regarding contract updates, Health Care Reform, claims filing and more!

- **Fee Adjustment Notifications** – If there is a change to an existing fee schedule, Anthem Blue Cross and Blue Shield provides notification of that occurrence.

- **Annual CDT Updates** –CDT Dental Procedure Codes are the source for dentists to code and document services accurately for claims submissions and dental records. CDT codes are updated with new procedure codes, revised procedure codes and deleted procedure codes on an annual basis.

- **Healthcare Reform Updates** – Anthem Blue Cross and Blue Shield provides information on changes with the Affordable Care Act (ACA) that may affect a dental practice.

- **Contract Provision Amendments and Updates** – Anthem Blue Cross and Blue Shield provides updates as they occur.

- **Dental Dispatch** – This newsletter is one of the Anthem Blue Cross and Blue Shield communication resources available to dental providers to keep them informed about all of the updates above and more.
    - The Spring/Summer version is electronic and is posted to the website (website information listed below)
    - The Fall/Winter version is mailed to participating providers, but is also posted to the website (website information listed below)

Where can you find this information?

Please visit our dental provider resources page at **www.anthem.com/provider/dental/**

Section 8: Administrative Guidelines and Network Bulletins

About Administrative Guidelines/Network Bulletins

The following outlines specific requirements/administrative guidelines/polices that a Participating Dentist is required to comply with in accordance with the Anthem Blue Cross and Blue Shield Participating Dentist Agreement. The vehicles which Anthem Dental may use to provide notice of these specific requirements/administrative guidelines/policies are mentioned in Sections 13. Amendment and 14. State/ Program Specific Regulatory Exhibits, "The vehicles which Anthem Dental may use to provide this notice include, but are not limited to, electronic communications, newsletters, general correspondence and Dentist provider manuals."

Connecticut

Quality Assurance Timely Access to Care

As an Anthem contracted Participating Dentist, you agreed to abide with the provisions of the Plan Quality Assurance Program including the approved accessibility standards. The Plan's access standards are as follows:

- Urgent Care: Within 48 Hours
- Non-Urgent appointments for general dentist: Within 10 business days
- Non-Urgent appointments for specialist care: Within 15 business days

Providers are expected to reschedule a patient/members appointment in a manner that is appropriate to the patient/member dental care needs.

Emergency appointments need to be available as necessitated by the patient/member dental condition. This requires that the dentist be on call 24 hours a day 7 days a week to assess the patient/member needs and determine when the patient/member should be seen. This availability requires the Anthem contracted Participating Dentist to use an answering service, telephone answering machine that is monitored for emergency telephone calls or other means of contacting the Anthem contracted Participating Dentist.

Providers must accept and treat all patients presenting themselves as Anthem Dental members and may not close their office to accepting new Anthem Dental members throughout the duration of an active Anthem Dental Provider Agreement.

General Statutes § 38a-472f

In accordance with Connecticut General Statutes § 38a-472f, upon receiving or submitting a termination notice, Dentist is required to provide a list of Covered Persons/patients of record to Anthem Dental within 30 days of such notice.

Connecticut HB 5383

Anthem Blue Cross and Blue Shield has incorporated language into our Connecticut Provider Agreements amends the current statute related to provider network contracting. The revised requirements extends the termination or non-renewal notice period of contracts between dental carriers and participating providers from 60 days to 90 days.

The **ANTHEM BLUE CROSS AND BLUE SHIELD PARTICIPATING DENTIST AGREEMENT, PPO-03G**, **ARTICLE VII GENERAL PROVISIONS**, has been amended by the addition of subsection 7.17 as follows:

7.17 Hold Harmless. In no event, including, but not limited to, nonpayment by *Anthem*, insolvency of *Anthem*, or breach of contract between *Anthem* and *Dentist*, shall *Dentist* bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Covered Person or a Covered Person's designee, other than *Anthem*, for Covered Services provided, except that Dentist may collect any Cost Share.

Colorado Bill CO HB1173

Colorado Bill CO HB1173

Anthem Blue Cross and Blue Shield has incorporated language into our Colorado Provider Agreements in order to comply with Colorado Bill CO HB1173.

This Bill provides the following rights to all Anthem Blue Cross and Blue Shield Participating Providers: Neither party is prohibited from protesting or disagreeing with a dental decision, dental policy or dental practice of the Dentist or Anthem Dental.

Anthem Dental may not take an adverse action against Dentist for:

1) Disagreeing with any coverage decision made by Anthem Dental,
2) Assisting a Covered Person/Member in seeking reconsideration of a coverage decision; or
3) For discussing with a current, former, or prospective patient any aspect of the patient's medical condition, any proposed treatments or treatment alternatives, whether covered by the plan or not, policy provisions of a plan, or a Dentist's personal recommendation regarding selection of a plan based on the Dentist's personal knowledge of the health needs of such patients.

Additionally, Anthem Dental may not take adverse action against Dentist, if Dentist acts in good faith, any of the following:

(a) Communicates with a public official or other person concerning public policy issues related to healthcare items or services;
(b) Files a complaint, makes a report, or comments to an appropriate governmental body regarding actions, policies, or practices of the carrier the provider believes might negatively affect the quality of, or access to, patient care;
(c) Provides testimony, evidence, opinion, or any other public activity in any forum concerning a violation or possible violation of any provision of this section;
(d) Reports what the provider believes to be a violation of law to an appropriate authority; or
(e) Participates in any investigation into a possible violation of any provision of this section.

Third-Party Access for Nevada and Virginia Providers

Nevada – SB365, Virginia – HB1682

In accordance with the below mentioned State Law on Third Party access and Network leasing, you may find a List of our Third Party and other payors available on our website in the Communications section. For Nevada, visit http://bit.ly/NevadaSB365. For Virginia, visit http://bit.ly/VirginiaHB1682.

Continuity of Care

Except when termination occurs due to a loss of license, Dentist, upon termination, of their Agreement or the loss of a Covered Person's eligibility, will continue to provide Covered Services to Covered Persons if a multi-step procedure is already in progress, to the extent that it is a requirement of applicable state law or regulations. Dentist must accept terms of payment under their Agreement for only that service until such service is completed. Includes, but is not limited to, multi-staged type treatments (i.e. crowns, bridges, dentures, root canals).